

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 1, 2018 - September 30, 2018

Respectfully Submitted By

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

Donald J. Fletcher
Independent Reviewer
December 13, 2018

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I. EXECUTIVE SUMMARY

This is the Independent Reviewer's thirteenth Report on the status of compliance with the Settlement Agreement (Agreement) between the parties to the Agreement: the Commonwealth of Virginia (the Commonwealth) and the United States, represented by the Department of Justice (DOJ). This Report documents and discusses the Commonwealth's efforts and the status of its progress and compliance during the thirteenth review period from April 1, 2018 through September 30, 2018.

The Governor of the Commonwealth approved the emergency revised Department of Behavioral Health and Developmental Services (DBHDS) Licensing Rules and Regulations (Regulations) for implementation in September 2018. The Commonwealth's completion of the multi-step approval process required to modify its regulations is an important and positive step. Now, in the seventh year of implementation, the Commonwealth is positioned to make substantial progress toward compliance in areas where progress has been very slow. Although approval of the revised Regulations is a critical first step, a substantial, concerted and focused effort will be needed by the Commonwealth, Community Service Boards (CSBs) and providers to fulfill the related provisions of the Agreement. During the first six years of the Agreement, the Independent Reviewer reported repeatedly that the Commonwealth's vague and dated regulations did not align with the provisions of the Agreement and hindered its ability to comply with many provisions of the Agreement, especially the various requirements related to developing and implementing a quality and risk management system.

The DBHDS Office of Licensing had made preparations to implement the Regulations. With approval of the revised Regulations in September, the final month of the thirteenth review period, however, substantive implementation will commence during the next review period. The updated and clarified expectations that are included in the emergency Regulations will require all licensed providers to implement quality improvement and risk management programs and to report data to the Commonwealth, as prescribed. The revisions also clarify and expand expectations for Case Managers' face-to-face visits and their direct assessments of whether the individuals' support plans remain appropriate and are being implemented appropriately. The Regulations also increase expectations regarding the content and review of Individual Support Plans (ISP).

For each individual with intellectual and/or developmental disabilities (IDD), the quality of daily services depends on the competence and caring of the individual's support staff and on the effectiveness of the service provider. The Agreement requires that all staff be trained to understand the performance expectations of their respective roles and to demonstrate competence (i.e., competency-based training). It also requires that all service providers function with quality improvement and risk management programs in place to ensure the health, safety, and well-being of the individuals served. Each of these requirements represents a cornerstone for the delivery of services that are of consistently good quality and that support individuals to achieve positive outcomes. To ensure that providers effectively implement these cornerstone responsibilities, the Commonwealth committed in the Agreement to develop and implement two external oversight mechanisms:

- Case Managers will assess whether the individual's supports are being implemented appropriately and remain appropriate, and
- The DBHDS Licensing process will assess the adequacy of individualized supports provided.

The revisions to the Regulations are consistent with the above requirements. They also encompass requirements that providers and Case Managers report to the Commonwealth consistently. The

revisions require providers to submit reliable data regarding the quality of services provided, including positive and negative outcomes. These data are essential for the Commonwealth to fulfill its responsibilities to collect and analyze reliable data to improve the availability, accessibility, and quality of services. Developing and implementing that system will require a major undertaking.

The Independent Reviewer determined that, prior to clarifying its Regulations, the Commonwealth had not yet effectively implemented, and therefore remains in non-compliance with, many of the Agreement's Quality and Risk Management System (Section V.) provisions. In addition to not implementing the two external oversight mechanisms, the Commonwealth had not implemented the uniform risk triggers and thresholds; the collection and analysis of consistent reliable data regarding the availability, accessibility and quality of services; the review of data by the Regional Quality Councils; or provider-based quality improvement and risk management programs.

In the areas prioritized by the Independent Reviewer for study during the thirteenth period, it is very positive that the Commonwealth sustained compliance achieved in prior periods. It bodes well for the future when system-wide improvements become reliable and standard practices. For the provisions studied during the thirteenth period, the Commonwealth continued to make substantive progress in several areas. In addition to the approval of the emergency revised Licensing Regulations, other system wide improvements included the following achievements:

- Many more individuals had enrolled in Supported Employment and in the new integrated day waiver-funded service models, such as Community Engagement and Community Coaching.
- More individuals were living in smaller and more integrated residential settings;
- REACH's mobile crisis service programs were found to have consistently offered in-home mobile supports; and,
- The Offices of Licensing and Human Rights achieved compliance with the investigation requirement of the Agreement for the first time.

Nonetheless, the Independent Reviewer found during this review period that the Commonwealth had not yet adequately addressed many other important challenges. The Individual Services Review study found that the families of individuals with intensive behavioral needs, and the agencies that provide needed in-home supports, had great difficulty recruiting and retaining direct support staff for the wage rates currently offered. Many of these individuals' services were not implemented adequately or appropriately because they were frequently not being delivered, occasionally for months, due to the lack of available direct support staff.

Once again, most Case Managers do not fulfill the Agreement's requirements regarding 1) offering, each year, a choice of service providers, including of Case Manager; 2) developing goals and discussing employment services as the first option; 3) submitting timely referrals to the Regional Support Teams; or 4) assessing whether individuals' support plans are being implemented appropriately. For example, the Individual Services Review study of individuals with intense behavioral needs again found that behavioral programming was frequently not available or inadequate. Yet, Case Managers had not identified or reported the qualitative shortcoming of services not being implemented appropriately and had not convened the individuals' service planning teams to address the identified concerns.

The Commonwealth does not have nearly enough qualified behavior specialists available to meet the needs of individuals with IDD. As a result, the behavioral programming provided is substantially inadequate compared to generally accepted practices. It is notable that neither of the Commonwealth's

external oversight mechanisms, the licensing process or Case Manager visits, identified lack of availability or the inadequate implementation of behavioral supports. The study of behavioral programming found that individuals identified as receiving formal behavioral supports did not have adequate functional behavioral assessments and their behavioral programming did not meet standards of generally accepted practice.

In fairness, the Commonwealth had projected that its planned improvements to case management functioning would not be evident in individual service planning documents until 2019. The Individual Services Review study involved individuals who had received services for at least a year and who had a new start date in April 2018. The case management documents that were reviewed for the Individual Services Review study were from 2017 through August 2018, prior to the date of expected impact of the Commonwealth and CSB improvement initiatives.

The challenges of recruiting and retaining direct support professionals (DSP) and not filling approved hours were very similar to prior findings regarding in-home nurses for individuals with medical needs. The DMAS and DBHDS leaders recognize that the failure to provide approved in-home DSP and nursing hours is a significant problem. After studying the challenges related to providing in-home nursing services, DMAS and DBHDS implemented more comprehensive initiatives, including requesting higher rates for nursing services. In November, when this Report was being written, the Governor was considering the DMAS rate increase proposal for his Fiscal Year 2020 budget request.

The “Summary of Compliance” table that follows provides a rating of compliance and an explanatory comment for each provision. The “Discussion of Compliance Findings” section includes additional information to explain the compliance ratings, as do the consultant reports, which are included in the Appendices. The Independent Reviewer’s recommendations are included at the end of this Report. Only the provisions with compliance determination in bolded print were reviewed and rated during the thirteenth period. The other compliance determinations were established during previous review periods. Facts will be gathered, analyzed and compliance determinations will be made for most of these provisions during the next, the fourteenth, review period.

During the next review period, the Independent Reviewer will prioritize monitoring the status of the Commonwealth’s compliance with the requirements of the Agreement in the following areas: creating waiver slots, children in nursing and Intermediate Care Facilities, the Individual and Family Support Program, Case Management, Family and Peer Programs, Family Guidelines, Independent Housing, and individuals who have transitioned from the Training Centers to community-based settings.

Throughout the thirteenth period, the Commonwealth’s staff have been accessible, forthright and responsive. Attorneys from DOJ continued to gather information that has helped accomplish effective implementation of the Agreement. They have worked collaboratively with the Commonwealth in negotiating outcomes and timelines for achieving the Agreement’s provisions. Overall, the willingness of both parties to openly and regularly discuss implementation issues, and any concerns about progress towards shared goals, has been critical and productive. The involvement and contributions of the advocates and other stakeholders have helped the Commonwealth make measurable progress. The Independent Reviewer greatly appreciates the assistance that was so generously given by the individuals at the center of this Agreement and their families, their Case Managers and their service providers.

II. SUMMARY OF COMPLIANCE

Settlement Agreement Reference	Provision	Rating	Comments
III	Serving Individuals with Developmental Disabilities in the Most Integrated Setting	<p>Compliance ratings for the ninth, eleventh, twelfth and thirteenth periods are presented as:</p> <p style="text-align: center;">(9th period) 11th period <u>12th period</u> 13th period</p>	<p>Comments include examples to explain the ratings and status. The Findings Section and attached consultant reports include additional explanatory information.</p> <p><i>The Comments in italics below are from a prior period when the most recent compliance rating was determined.</i></p>
III.C.1.a.i-vii	The Commonwealth shall create a minimum of 805 waiver slots to enable individuals in the target population in the Training Centers to transition to the community ... vii. In State Fiscal Year 2018, 90 waiver slots	<p>(Compliance) Compliance</p> <p style="text-align: center;"><u>Compliance</u></p>	<i>The Commonwealth created 100 Community Living waiver slots during FY 2018, ten more than the minimum number required for individuals to transition from Training Centers.</i>
III.C.1.b.i-vii	The Commonwealth shall create a minimum of 2,915 waiver slots to prevent the institutionalization of individuals with intellectual disabilities in the target population who are on the urgent waitlist for a waiver, or to transition to the community, individuals with intellectual disabilities under 22 years of age from institutions other than the Training Centers (i.e., ICFs and nursing facilities) ... vii. In State Fiscal Year 2018, 325 waiver slots.	<p>(Non Compliance) Non Compliance</p> <p style="text-align: center;"><u>Non Compliance</u></p>	<i>The Commonwealth created 424 new waiver slots in FY 2018 exceeding the total required for the former ID and IFDDS slots. Children have transitioned from one nursing facility; older children only have been transitioned from the two largest private ICFs. For III.C.1. b. and c., only 32 of the 180 (17.8%) prioritized slots have been used; an additional 30 non-prioritized slots have been used. See Findings III.B. for more information.</i>

Settlement Agreement Reference	Provision	Rating	Comments
<u>III.C.1.c.i-vii</u>	The Commonwealth shall create a minimum of 450 waiver slots to prevent the institutionalization of individuals with developmental disabilities other than intellectual disabilities in the target population who are on the waitlist for a waiver, or to transition to the community individuals with developmental disabilities other than intellectual disabilities under 22 years of age from institutions other than the Training Centers (i.e., ICFs and nursing facilities) ... vii. In State Fiscal Year 2018, 25 waiver slots, including 10 prioritized for individuals under 22 years of age residing in nursing homes and the largest ICFs	(Non Compliance) Non Compliance <u>Non Compliance</u>	<i>The Commonwealth created 424 new waiver slots in FY 2018 exceeding the total required for the former ID and IFDDS slots. Children have transitioned from one nursing facility; older children only have been transitioned from two living ICFs. For III.C.1. b. and c., only 32 of the 180 (17.8%) prioritized slots have been used; an additional 30 non-prioritized slots have been used. See Findings III.B. for more information.</i>
<u>III.C.2.a-b</u>	The Commonwealth shall create an Individual and Family Support Program (IFSP) for individuals with ID/DD whom the Commonwealth determines to be the most at risk of institutionalization. In the State Fiscal Year 2018, a minimum of 1000 individuals will be supported.	(Non Compliance) <u>Non Compliance</u>	<i>The Commonwealth continues to meet the quantitative requirement. DBHDS completed a strategic plan which outlines a path to compliance; implementation will not be evident until 2019.</i>
<u>III.C.5.a</u>	The Commonwealth shall ensure that individuals receiving HCBS waiver services under this Agreement receive case management.	(Compliance) Compliance <u>Compliance</u> Compliance	<i>99 (100%) of the individuals reviewed in the individual services review studies during the 10th, 11th, 12th, and 13th periods had case managers and current Individual Support Plans.</i>
<u>III.C.5.b.</u>	For the purpose of this agreement, case management shall mean:		
<u>III.C.5.b.i.</u>	Assembling professionals and nonprofessionals who provide individualized supports, as well as the individual being served and other persons important to the individual being served, who, through their combined expertise and involvement, develop Individual Support Plans (“ISP”) that are individualized, person-centered, and meet the individual’s needs.	Non Compliance	<i>The Individual Services Review and Case management studies found continuing inadequacies in case management performance. The Commonwealth informed the Independent Reviewer its Case Management improvement initiatives will not be evident until 2019.</i>

Settlement Agreement Reference	Provision	Rating	Comments
III.C.5.b.ii	Assisting the individual to gain access to needed medical, social, education, transportation, housing, nutritional, therapeutic, behavioral, psychiatric, nursing, personal care, respite, and other services identified in the ISP.	Non Compliance	<i>See comment immediately above.</i>
III.C.5.b.iii	Monitoring the ISP to make timely additional referrals, service changes, and amendments to the plans as needed.	Non Compliance	<i>See comment regarding III.C.5.b.i.</i>
III.C.5.c	Case management shall be provided to all individuals receiving HCBS waiver services under this Agreement by case managers who are not directly providing such services to the individual or supervising the provision of such services. The Commonwealth shall include a provision in the Community Services Board (“CSB”) Performance Contract that requires CSB case managers to give individuals a choice of service providers from which the individual may receive approved waiver services and to present practicable options of service providers based on the preferences of the individual, including both CSB and non-CSB providers.	(Deferred) Non Compliance <u>Non Compliance</u> Non Compliance	The Individual Services Review studies during the 10 th , 11 th , 12 th and 13 th periods found that case managers had offered choices of residential and day providers. For the sample studied during the 13 th period, however, an offer of a choice of case managers was documented for only 1 of 29 (3.4%) individuals.
III.C.5.d	The Commonwealth shall establish a mechanism to monitor compliance with performance standards.	(Non Compliance) Non Compliance Non Compliance	Licensing protocols do not include a review of the adequacy of case management services, including a review of whether case managers are fulfilling their responsibilities to determine whether services are being delivered appropriately and remain appropriate to the individual.

Settlement Agreement Reference	Provision	Rating	Comments
<u>III.C.6.a.i-iii</u>	<p>The Commonwealth shall develop a statewide crisis system for individuals with intellectual and developmental disabilities. The crisis system shall:</p> <p>i. Provide timely and accessible support ...</p> <p>ii. Provide services focused on crisis prevention and proactive planning ...</p> <p>iii. Provide in-home and community-based crisis services that are directed at resolving crises and preventing the removal of the individual ...</p>	<p>(Non Compliance) Non Compliance <u>Non Compliance</u></p> <p>Non Compliance</p>	<p>This is an overarching provision. Compliance will not be achieved until the Commonwealth is in compliance with the components of Crisis Services as specified in the provisions of the Agreement.</p>
<u>III.C.6.b.i.A</u>	<p>The Commonwealth shall utilize existing CSB Emergency Services, including existing CSB hotlines, for individuals to access information about referrals to local resources. Such hotlines shall be operated 24 hours per day, 7 days per week.</p>	<p>(Compliance) Compliance <u>Compliance</u></p> <p>Compliance</p>	<p>CSB Emergency Services are utilized. REACH hotlines are operated 24 hours per day, 7 days per week, for adults and for children with ID/DD.</p>
<u>III.C.6.b.i.B</u>	<p>By June 30, 2012, the Commonwealth shall train CSB Emergency Services (ES) personnel in each Health Planning Region on the new crisis response system it is establishing, how to make referrals, and the resources that are available.</p>	<p>(Compliance) Compliance <u>Compliance</u></p>	<p><i>REACH trained 2,173 CSB staff and 607 ES staff during the past three years. The Commonwealth requires that all ES staff and case managers are required to attend training.</i></p>
<u>III.C.6.b.ii.A</u>	<p>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.</p>	<p>Non Compliance <u>Non Compliance</u></p>	<p><i>The CSB - ES are not typically dispatching mobile crisis team members to respond to individuals at their homes. Instead the CSB-ES continues the pre-Agreement practice of meeting individuals in crisis at hospitals or at CSB offices. This practice prevents the provision of supports to deescalate crises.</i></p>
<u>III.C.6.b.ii.B</u>	<p>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.</p>	<p>Non Compliance <u>Non Compliance</u></p> <p>Non Compliance</p>	<p><i>See comment immediately above re: III.C.6.b.ii.A. In addition, during the 13th period, two of the three Regions studied completed fewer than eighty percent of the DBHDS expectations for Crisis Education and Prevention Plans.</i></p>

Settlement Agreement Reference	Provision	Rating	Comments
<u>III.C.6.b.ii.C</u>	Mobile crisis team members adequately trained to address the crisis also shall work with law enforcement personnel to respond if an individual with IDD comes into contact with law enforcement.	(Compliance) Compliance <u>Compliance</u>	<i>During the past three years, REACH children's and adult programs have trained 3,288 law enforcement personnel.</i>
<u>III.C.6.b.ii.D</u>	Mobile crisis teams shall be available 24 hours per day, 7 days per week and to respond on-site to crises.	(Compliance) Compliance <u>Compliance</u>	<i>REACH Mobile crisis teams for children and adults are available around the clock and respond on-site at all hours of the day and night.</i>
<u>III.C.6.b.ii.E</u>	Mobile crisis teams shall provide local and timely in-home crisis support for up to three days, with the possibility of an additional period of up to 3 days upon review by the Regional Mobile Crisis Team Coordinator	(Compliance) Compliance <u>Compliance</u> Compliance	REACH teams offered in-home mobile supports to all of the individuals in the selected sample of forty individuals and provided them to all who accepted REACH services. Hours ranged between a low of one and a high of eleven days.
<u>III.C.6.b.ii.H</u>	By June 30, 2014, the Commonwealth shall have a sufficient number of mobile crisis teams in each Region to respond to on-site to crises as follows: in urban areas within one hour, in rural areas within two hours, as measured by the average annual response time.	(Compliance) Compliance <u>Compliance</u>	<i>The Commonwealth did not create new teams. It added staff to the existing teams. REACH teams in all five Regions responded within the required average annual response times during the eleventh review period.</i>
<u>III.C.6.b.iii.A.</u>	Crisis Stabilization programs offer a short-term alternative to institutionalization or hospitalization for individuals who need inpatient stabilization services	(Compliance) Compliance <u>Compliance</u>	<i>All Regions continue to have crisis stabilization programs that are providing short-term alternatives for adults with ID/DD.</i>
<u>III.C.6.b.iii.B.</u>	Crisis stabilization programs shall be used as a last resort. The State shall ensure that, prior to transferring an individual to a crisis stabilization program, the mobile crisis team, in collaboration with the provider, has first attempted to resolve the crisis to avoid an out-of-home placement and, if that is not possible, has then attempted to locate another community-based placement that could serve as a short-term placement.	(Non Compliance) Non Compliance <u>Non Compliance</u>	<i>For adults with ID/DD admitted to the programs, crisis stabilization programs continue to be used as a last resort. For these individuals, teams attempted to resolve crises and avoid out-of-home placements.</i>
<u>III.C.6.b.iii.D.</u>	Crisis stabilization programs shall have no more than six beds and lengths of stay shall not exceed 30 days.	(Non Compliance) Non Compliance <u>Non Compliance</u>	<i>Each Region's crisis stabilization program continues to routinely have stays that exceed 30 days, which are not allowed. Transitional and therapeutic homes that allow long-term stays are being developed.</i>

Settlement Agreement Reference	Provision	Rating	Comments
<u>III.C.6.b.iii.E.</u>	With the exception of the Pathways Program at SWVTC ... crisis stabilization programs shall not be located on the grounds of the Training Centers or hospitals with inpatient psychiatric beds. By July 1, 2015, the Pathways Program at SWVTC will cease providing crisis stabilization services and shall be replaced by off-site crisis stabilization programs with sufficient capacity to meet the needs of the target population in that Region.	(Non Compliance) Non Compliance <u>Non Compliance</u>	<i>The Commonwealth does not have sufficient community-based crisis stabilization service capacity to meet the needs of the target population in the Region.</i>
<u>III.C.6.b.iii.F.</u>	By June 30, 2012, the Commonwealth shall develop one crisis stabilization program in each Region.	(Compliance) Compliance <u>Compliance</u>	<i>Each Region developed and currently maintains a crisis stabilization program for adults with ID/DD.</i>
<u>III.C.6.b.iii.G.</u>	By June 30, 2013, the Commonwealth shall develop an additional crisis stabilization program in each Region as determined necessary by the Commonwealth to meet the needs of the target population in that Region.	(Non Compliance) Non Compliance <u>Non Compliance</u>	<i>The Commonwealth has determined that it is not necessary to develop additional “crisis stabilization programs” for adults in each Region. It has decided to add, but not yet developed two programs statewide to meet the crisis stabilization needs of adults who require longer stays. Children’s crisis stabilization programs are also planned but developments have again been delayed.</i>
<u>III.C.7.a</u>	To the greatest extent practicable, the Commonwealth shall provide individuals in the target population receiving services under this Agreement with integrated day opportunities, including supported employment.	(Non Compliance) Non Compliance Non Compliance	This is an overarching provision. Compliance will not be achieved until the component provisions of integrated day, including supported employment, are in compliance.
<u>III.C.7.b</u>	The Commonwealth shall maintain its membership in the State Employment Leadership Network (“SELN”) established by the National Association of State Developmental Disabilities Directors. The Commonwealth shall establish a state policy on Employment First for the target population and include a term in the CSB Performance Contract requiring application of this policy... (3) employment services and goals <u>must be developed and discussed at least annually</u> through a person-centered planning process and included in the ISP.	(Non Compliance) Non Compliance <u>Non Compliance</u> Non Compliance	The Individual Services Review study found that employment services and goals were <u>not</u> developed and discussed for 22 of 25 individuals (88.0%). ISP documents had boxes checked to indicate employment was discussed, but there were no records that goals were developed and discussed to pursue employment as the first option.

Settlement Agreement Reference	Provision	Rating	Comments
<u>III.C.7.b.i.</u>	Within 180 days of this Agreement, the Commonwealth shall develop, as part of its Employment First Policy, an implementation plan to increase integrated day opportunities for individuals in the target population, including supported employment, community volunteer activities, community recreation opportunities, and other integrated day activities.	<u>Non</u> (Compliance) Compliance Compliance	<i>The Commonwealth had previously developed a plan for Supported Employment. It has revised and improved its implementation plan with stronger and required elements for integrated day opportunities/activities.</i>
<u>III.C.7.b.i.A.</u>	Provide regional training on the Employment First policy and strategies through the Commonwealth.	(Compliance) Compliance Compliance	DBHDS continued to provide regional training on the Employment First policy and strategies.
<u>III.C.7.b.i.</u> <u>B.1.</u>	Establish, for individuals receiving services <u>through the HCBS waivers</u> , annual baseline information regarding:	Compliance Compliance	The Commonwealth has significantly improved its method of collecting data. For the third consecutive period, data were reported by 100% of the employment service providers. It can now report the number of individuals, length of time, and earnings as required in III.C.7.b.i.B.1.a, b, c, d, and e below.
<u>III.C.7.b.i.</u> <u>B.1.a.</u>	The number of individuals who are receiving supported employment.	(Compliance) Compliance Compliance	<u>See answer for III.C.7.b.i.B.1.</u>
<u>III.C.7.b.i.</u> <u>B.1.b.</u>	The length of time individuals maintain employment in integrated work settings.	(Compliance) Compliance Compliance	<u>See answer for III.C.7.b.i.B.1.</u>
<u>III.C.7.b.i.</u> <u>B.1.c.</u>	Amount of earnings from supported employment;	(Compliance) Compliance Compliance	<u>See answer for III.C.7.b.i.B.1.</u>
<u>III.C.7.b.i.</u> <u>B.1.d.</u>	The number of individuals in pre-vocational services.	(Compliance) Compliance Compliance	<u>See answer for III.C.7.b.i.B.1.</u>
<u>III.C.7.b.i.</u> <u>B.1.e.</u>	The length-of-time individuals remain in pre-vocational services.	(Compliance) Compliance Compliance	<u>See answer for III.C.7.b.i.B.1.</u>

Settlement Agreement Reference	Provision	Rating	Comments
<u>III.C.7.b.i.</u> <u>B.2.a.</u>	Targets to meaningfully increase: the number of individuals who enroll in supported employment each year.	(Compliance) Non Compliance Non Compliance	The Commonwealth set targets to meaningfully increase the number. By the end of Fiscal Year 2018, the number of individuals with HCBS waivers had increased substantially, but only to 74.9% of the target. Systemic obstacles have not been addressed.
<u>III.C.7.b.i.</u> <u>B.2.b</u>	The number of individuals who remain employed in integrated work settings at least 12 months after the start of supported employment.	(Compliance) Compliance Compliance	Of the number of individuals who were employed in June 2017, 91% had retained their jobs twelve months later in June 2018, which exceeded the 85% target set in 2014.
III.C.7.c.	Regional Quality Councils (RQC), described in V.D.5. ... shall review data regarding the extent to which the targets identified in Section III.C.7.b.i.B.2 above are being met. These data shall be provided quarterly ... Regional Quality Councils shall consult with providers with the SELN regarding the need to take additional measures to further enhance these services.	(Compliance) Compliance Compliance	The RQCs continue to meet each quarter, to consult with the DBHDS Employment staff, both members of the SELN (aka EFAG), and to review progress toward targets.
III.C.7.d.	The Regional Quality Councils shall annually review the targets set pursuant to Section III.C.7.b.i.B.2 above and shall work with providers and the SELN in determining whether the targets should be adjusted upward.	(Compliance) Compliance Compliance	The RQCs reviewed the employment targets and the State's progress for FY 2018. The RQCs have discussed and endorsed the future FY 2016 - 2019 targets.
III.C.8.a.	The Commonwealth shall provide transportation to individuals receiving HCBS waiver services in the target population in accordance with the Commonwealth's HCBS Waivers.	(Non Compliance) Non Compliance	<i>A review found that DMAS /Broker have implemented previous recommendations and DMAS added them to its RFP, which it has had to reissue. Sustained improvements and a functioning quality improvement program will not be able to be evaluated until 2019.</i>
<u>III.C.8.b.</u>	The Commonwealth shall publish guidelines for families seeking intellectual and developmental disability services on how and where to apply for and obtain services. The guidelines will be updated annually and will be provided to appropriate agencies for use in directing individuals in the target population to the correct point of entry to access	(Non Compliance) <u>Non Compliance</u>	<i>DBHDS has developed a multi-part plan for publishing guidelines. Guidelines for the IFSP resources and strategies have not yet been developed and published, but the Commonwealth has made good progress.</i>

Settlement Agreement Reference	Provision	Rating	Comments
<u>III.D.1.</u>	The Commonwealth shall serve individuals in the target population in the most integrated setting consistent with their informed choice and needs.	(Non Compliance) Non Compliance	<i>This is an overarching provision. The need for more integrated settings will not be resolved until full implementation of the redesigned waivers and additional provider development, especially to serve individuals with intense needs.</i>
<u>III.D.2.</u>	The Commonwealth shall facilitate individuals receiving HCBS waivers under this Agreement to live in their own home, leased apartment, or family’s home, when such a placement is their informed choice and the most integrated setting appropriate to their needs. To facilitate individuals living independently in their own home or apartment, the Commonwealth shall provide information about and make appropriate referrals for individuals to apply for rental or housing assistance and bridge funding through all existing sources.	Compliance	<i>The Commonwealth has created 553 independent housing options and is almost a year ahead of its goal to achieve 847 new options by FY2021.</i>
<u>III.D.3.</u>	Within 365 days of this Agreement, the Commonwealth shall develop a plan to increase access to independent living options such as individuals’ own homes or apartments.	(Compliance) Compliance	<i>The Commonwealth developed a plan, created strategies to improve access, and provided rental subsidies.</i>
<u>III.D.3.a.</u>	The plan will be developed under the direct supervision of a dedicated housing service coordinator for the Department of Behavioral Health and Developmental Services (“DBHDS”) and in coordination with representatives from the Department of Medical Assistance Services (“DMAS”), Virginia Board for People with Disabilities, Virginia Housing Development Authority, Virginia Department of Housing and Community Development, and other organizations ...	(Compliance) Compliance	<i>A DBHDS housing service coordinator developed and updated the plan with these representatives and with others.</i>

Settlement Agreement Reference	Provision	Rating	Comments
<u>III.D.3.b.i-ii</u>	The plan will establish for individuals receiving or eligible to receive services through the HCBS waivers under this Agreement: Baseline information regarding the number of individuals who would choose the independent living options described above, if available; and recommendations to provide access to these settings during each year of this Agreement.	(Compliance) Compliance	<i>The Commonwealth estimated the number of individuals who would choose independent living options. It again revised its Housing Plan with new strategies and recommendations.</i>
<u>III.D.4</u>	Within 365 days of this Agreement, the Commonwealth shall establish and begin distributing from a one-time fund of \$800,000 to provide and administer rental assistance in accordance with the recommendations described above in Section III.D.3.b.ii.	(Compliance) Compliance and Completed	The Commonwealth established the one-time fund, distributed funds, and demonstrated viability of providing rental assistance. The individuals who received these one-time funds have been provided permanent rental assistance.
<u>III.D.5</u>	Individuals in the target population shall not be served in a sponsored home or any congregate setting, unless such placement is consistent with the individual’s choice after receiving options for community placements, services, and supports consistent with the terms of Section IV.B.9 below.	Non Compliance <u>Non Compliance</u>	<i>Family-to-family and peer programs were not active for individuals who live in the community and their families, however, DBHDS is making progress.</i>
<u>III.D.6</u>	No individual in the target population shall be placed in a nursing facility or congregate setting with five or more individuals unless such placement is consistent with the individual’s needs and informed choice and has been reviewed by the Region’s Community Resource Consultant (CRC) and, under circumstances described in Section III.E below, the Regional Support Team (RST).	Non Compliance <u>Non Compliance</u> Non Compliance	Although DBHDS has made substantive process improvements, case managers continue to submit RST referrals late (after or concurrent with the individual’s move) at approximately the same rate as it has previously.
<u>III.D.7</u>	The Commonwealth shall include a term in the annual performance contract with the CSBs to require case managers to continue to offer education about less restrictive community options on at least an annual basis to any individuals living outside their own home or family’s home ...	(Compliance) Compliance Compliance	The Commonwealth included this term in the performance contracts, developed and provided training to case managers and implemented an ISP form with education about less restrictive options.

Settlement Agreement Reference	Provision	Rating	Comments
III.E.1	The Commonwealth shall utilize Community Resource Consultant (“CRC”) positions located in each Region to provide oversight and guidance to CSBs and community providers, and serve as a liaison between the CSB case managers and DBHDS Central Office...The CRCs shall be a member of the Regional Support Team ...	(Compliance) Compliance <u>Compliance</u> Compliance	Community Resource Consultants (CRCs) are located in each Region, are members of the Regional Support Teams, and are utilized for these functions.
III.E.2	The CRC may consult at any time with the Regional Support Team (RST). Upon referral to it, the RST shall work with the Personal Support Team (“PST”) and CRC to review the case, resolve identified barriers, and ensure that the placement is the most integrated setting appropriate to the individual’s needs, consistent with the individual’s informed choice. The RST shall have the authority to recommend additional steps by the PST and/or CRC.	Non Compliance Compliance	DBHDS has reviewed and improved the RST processes. When case managers submit timely referrals, CRCs and the RSTs fulfill their roles and responsibilities and the Regional Support Teams frequently succeed at their core functions.
III.E.3.a-d	The CRC shall refer cases to the Regional Support Teams (RST) for review, assistance in resolving barriers, or recommendations whenever (specific criteria are met).	Compliance <u>Compliance</u> Compliance	DBHDS established the RSTs, which meet monthly. The CRCs refer cases to the RSTs as required.
IV	Discharge Planning and Transition	Compliance ratings for the ninth, eleventh, twelfth and thirteenth periods are presented as: (9 th period) 11 th period <u>12th period</u> 13 th period	Note: The Independent Reviewer gathered information about individuals who transitioned from Training Centers and rated compliance during the first, third, fifth, seventh, ninth and twelfth review periods. <i>The Comments in italics below are from the period when the compliance rating was determined.</i>
IV.	By July 2012, the Commonwealth will have implemented Discharge and Transition Planning processes at all Training Centers consistent with the terms of this section	(Compliance) <u>Compliance</u>	<i>The Commonwealth developed and implemented discharge planning and transition processes prior to July 2012. It has continued to implement improvements in response to concerns the IR identified.</i>

Settlement Agreement Reference	Provision	Rating	Comments
IV.A	To ensure that individuals are served in the most integrated setting appropriate to their needs, the Commonwealth shall develop and implement discharge planning and transition processes at all Training Centers consistent with the terms of this Section and person-centered principles.	(Non Compliance) <u>Non Compliance</u>	<i>This is an overarching provision of the Agreement. Compliance will not be achieved until the component sub-provisions in the Discharge section are determined to be in compliance.</i>
IV.B.3.	Individuals in Training Centers shall participate in their treatment and discharge planning to the maximum extent practicable, regardless of whether they have authorized representatives. Individuals shall be provided the necessary support (including, but not limited to, communication supports) to ensure that they have a meaningful role in the process.	(Compliance) <u>Compliance</u>	<i>The Independent Reviewer's Individual Services Review studies found that DBHDS has consistently complied with this provision. The discharge plans reviewed were well organized and well documented.</i>
IV.B.4.	The goal of treatment and discharge planning shall be to assist the individual in achieving outcomes that promote the individual's growth, wellbeing, and independence, based on the individual's strengths, needs, goals, and preferences, in the most integrated settings in all domains of the individual's life (including community living, activities, employment, education, recreation, healthcare, and relationships).	(Non Compliance) <u>Non Compliance</u>	<i>Discharge plan goals did not include measurable outcomes that promote integrated day activities. None (0.0%) of the 19 individuals studied were offered integrated day opportunities and none (0.0%) had typical days that included regular integrated activities.</i>
IV.B.5.	The Commonwealth shall ensure that discharge plans are developed for all individuals in its Training Centers through a documented person-centered planning and implementation process and consistent with the terms of this Section. The discharge plan shall be an individualized support plan for transition into the most integrated setting consistent with informed individual choice and needs and shall be implemented accordingly. The final discharge plan will be developed within 30 days prior to discharge.	(Compliance) <u>Compliance</u>	<i>The Independent Reviewer's Individual Services Review studies found that DBHDS has consistently complied with this provision. The discharge plans are well documented. All individuals studied had discharge plans.</i>
IV.B.5.a.	Provision of reliable information to the individual and, where applicable, the authorized representative, regarding community options in accordance with Section IV.B.9;	(Compliance) <u>Compliance</u>	<i>The documentation of information provided was present in the discharge records</i> • for 45 (100%) of the individuals studied during the ninth and twelfth review period.

Settlement Agreement Reference	Provision	Rating	Comments
IV.B.5.b.	Identification of the individual's strengths, preferences, needs (clinical and support), and desired outcomes;	(Compliance) <u>Compliance</u>	<i>The discharge plans included this information.</i>
IV.B.5.c.	Assessment of the specific supports and services that build on the individual's strengths and preferences to meet the individual's needs and achieve desired outcomes, regardless of whether those services and supports are currently available;	(Compliance) <u>Compliance</u>	<i>• for 95 of 96 individuals (99.0%) studied during the fifth, seventh, ninth and twelfth review periods, the discharge records included these assessments.</i>
IV.B.5.d.	Listing of specific providers that can provide the identified supports and services that build on the individual's strengths and preferences to meet the individual's needs and achieve desired outcomes;	(Compliance) <u>Compliance</u>	<i>The PSTs select and list specific providers that provide identified supports and services.</i>
IV.B.5.e.	Documentation of barriers preventing the individual from transitioning to a more integrated setting and a plan for addressing those barriers.	(Compliance) <u>Compliance</u>	<i>The Training Centers document barriers in six broad categories as well as more specific barriers.</i>
IV.B.5.e.i.	Such barriers shall not include the individual's disability or the severity of the disability.	(Compliance) <u>Compliance</u>	<i>The severity of the disability has not been a barrier in the discharge plans.</i>
IV.B.5.e.ii.	For individuals with a history of re-admission or crises, the factors that led to re-admission or crises shall be identified and addressed.	(Compliance) <u>Compliance</u>	<i>DBHDS has identified the factors that led to readmission and has implemented steps to support individuals with intensive needs.</i>
IV.B.6	Discharge planning will be done by the individual's PST...Through a person-centered planning process, the PST will assess an individual's treatment, training, and habilitation needs and make recommendations for services, including recommendations of how the individual can be best served.	(Non Compliance) <u>Non Compliance</u>	<i>The Individual Services Review Study found that the discharge plans lacked recommendations for services in integrated day opportunities.</i>
IV.B.7	Discharge planning shall be based on the presumption that, with sufficient supports and services, all individuals (including individuals with complex behavioral and/or medical needs) can live in an integrated setting.	(Compliance) <u>Compliance</u>	<i>The Commonwealth's discharge plans indicate that individuals with complex needs can live in integrated settings.</i>

Settlement Agreement Reference	Provision	Rating	Comments
IV.B.9.	In developing discharge plans, PSTs, in collaboration with the CSB case manager, shall provide to individuals and, where applicable, their authorized representatives, specific options for types of community placements, services, and supports based on the discharge plan as described above, and the opportunity to discuss and meaningfully consider these options.	(Compliance) <u>Compliance</u>	<i>The Individual Services Review studies during the fifth, seventh, ninth and twelfth review periods found that □ 97 (100%) of individuals and their ARs were provided with information regarding community options and had the opportunity to discuss them with the PST.</i>
IV.B.9.a.	The individual shall be offered a choice of providers consistent with the individual's identified needs and preferences.	(Compliance) <u>Compliance</u>	<i>Discharge records included evidence that the Commonwealth had offered a choice of providers.</i>
IV.B.9.b.	PSTs and the CSB case manager shall coordinate with the ... community providers identified in the discharge plan as providing appropriate community-based services for the individual, to provide individuals, their families, and, where applicable, their authorized representatives with opportunities to speak with those providers, visit community placements (including, where feasible, for overnight visits) and programs, and facilitate conversations and meetings with individuals currently living in the community and their families, before being asked to make a choice regarding options. The Commonwealth shall develop family-to-family peer programs to facilitate these opportunities.	(Compliance) <u>Compliance</u>	<i>The ninth and twelfth individual services reviews found that • 39 of 45 individuals (86.7%) and their ARs did have an opportunity to speak with individuals currently living in their communities and their family members. All 100% received a packet of information with this offer, but discussions and follow-up were not documented for four individuals.</i>
<u>IV.B.9.c.</u>	PSTs and the CSB case managers shall assist the individual and, where applicable, their authorized representative in choosing a provider after providing the opportunities described above and ensure that providers are timely identified and engaged in preparing for the individual's transition.	(Compliance) <u>Compliance</u>	<i>PST's and case managers assisted individuals and their Authorized Representative. For 100% of the 45 individuals studied in the 9th and 12th ISR studies, providers were identified and engaged; provider staff were trained in support plan protocols.</i>

Settlement Agreement Reference	Provision	Rating	Comments
<u>IV.B.11.</u>	The Commonwealth shall ensure that Training Center PSTs have sufficient knowledge about community services and supports to: propose appropriate options about how an individual's needs could be met in a more integrated setting; present individuals and their families with specific options for community placements, services, and supports; and, together with providers, answer individuals' and families' questions about community living.	(Compliance) <u>Compliance</u>	<i>During the fifth, seventh, ninth and twelfth review periods, the reviews found that</i> • 89 of 97 individuals /Authorized Representatives (91.8%) who transitioned from Training Centers were provided with information regarding community options.
<u>IV.B.11.a.</u>	In collaboration with the CSB and Community providers, the Commonwealth shall develop and provide training and information for Training Center staff about the provisions of the Agreement, staff obligations under the Agreement, current community living options, the principles of person-centered planning, and any related departmental instructions. The training will be provided to all applicable disciplines and all PSTs.	(Compliance) <u>Compliance</u>	<i>The Independent Reviewer confirmed that training has been provided via regular orientation, monthly and ad hoc events at all Training Centers, and via ongoing information sharing.</i>
<u>IV.B.11.b.</u>	Person-centered training will occur during initial orientation and through annual refresher courses. Competency will be determined through documented observation of PST meetings and through the use of person-centered thinking coaches and mentors. Each Training Center will have designated coaches who receive additional training. The coaches will provide guidance to PSTs to ensure implementation of the person-centered tools and skills. Coaches ... will have regular and structured sessions and person-centered thinking mentors. These sessions will be designed to foster additional skill development and ensure implementation of person centered thinking practices throughout all levels of the Training Centers.	(Compliance) <u>Compliance</u>	<i>The Independent Reviewer confirmed that staff receive required person-centered training during orientation and annual refresher training. All Training Centers have person-centered coaches. DBHDS reports that regularly scheduled conferences provide opportunities to meet with mentors. An extensive list of trainings was provided and attendance is well documented.</i>

Settlement Agreement Reference	Provision	Rating	Comments
IV.C.3	<p>The Commonwealth shall develop and implement a system to follow up with individuals after discharge from the Training Centers to identify gaps in care and address proactively any such gaps to reduce the risk of re-admission, crises, or other negative outcomes. The Post Move Monitor, in coordination with the CSB, will conduct post-move monitoring visits within each of three (3) intervals (30, 60, and 90 days) following an individual's movement to the community setting. Documentation of the monitoring visit will be made using the Post Move Monitoring (PMM) Checklist. The Commonwealth shall ensure those conducting Post Move Monitoring are adequately trained and a reasonable sample of look-behind Post Move Monitoring is completed to validate the reliability of the Post Move Monitoring process.</p>	<p>(Compliance)</p> <p><u>Compliance</u></p>	<p><i>The Independent Reviewer determined the Commonwealth's PMM process is well organized. It functions with increased frequency during the first weeks after transitions.</i></p> <ul style="list-style-type: none"> • for 95 (100%) individuals PMM visits occurred. The monitors had been trained and utilized monitoring checklists. The look-behind process was maintained during the seventh period.
IV.C.4	<p>The Commonwealth shall ensure that each individual transitioning from a Training Center shall have a current discharge plan, updated within 30 days prior to the individual's discharge.</p>	<p>(Compliance)</p> <p><u>Compliance</u></p>	<p><i>The Individual Services Review studies during the ninth and twelfth review periods found that</i></p> <ul style="list-style-type: none"> • for 44 of 45 individuals (97.8%), the Commonwealth updated discharge plans within 30 days prior to discharge.
IV.C.5	<p>The Commonwealth shall ensure that the PST will identify all needed supports, protections, and services to ensure successful transition in the new living environment, including what is most important to the individual as it relates to community placement. The Commonwealth, in consultation with the PST, will determine the essential supports needed for successful and optimal community placement. The Commonwealth shall ensure that essential supports are in place at the individual's community placement prior to the individual's discharge.</p>	<p>(Non Compliance)</p> <p><u>Compliance</u></p>	<p><i>The Individual Review study found that essential supports were in place prior to discharge for 21 of the 26 individuals (80.8%) in the ninth period, which improved to 18 of the 19 individuals (94.7%) who were studied during the twelfth review periods.</i></p>

Settlement Agreement Reference	Provision	Rating	Comments
IV.C.6	No individual shall be transferred from a Training Center to a nursing home or congregate setting with five or more individuals unless placement in such a facility is in accordance with the individual’s informed choice after receiving options for community placements, services, and supports and is reviewed by the Community Integration Manager to ensure such placement is consistent with the individual’s informed choice.	(Compliance) <u>Compliance</u>	<i>The discharge records reviewed in the ninth and twelfth review periods indicated that individuals who moved to settings of five or more did so based on their informed choice after receiving options.</i>
IV.C.7	The Commonwealth shall develop and implement quality assurance processes to ensure that discharge plans are developed and implemented, in a documented manner, consistent with the terms of this Agreement. These quality assurance processes shall be sufficient to show whether the objectives of this Agreement are being achieved. Whenever problems are identified, the Commonwealth shall develop and implement plans to remedy the problems.	(Compliance) <u>Compliance</u>	<i>The Independent Reviewer confirmed that documented Quality Assurance processes have been implemented consistent with the terms of the Agreement. When problems have been identified, corrective actions have occurred with the discharge plans.</i>
IV.D.1	The Commonwealth will create Community Integration Manager (“CIM”) positions at each operating Training Center.	(Compliance) <u>Compliance</u>	<i>Community Integration Managers are working at each Training Center.</i>
IV.D.2.a	CIMs shall be engaged in addressing barriers to discharge, including in all of the following circumstances: The PST recommends that an individual be transferred from a Training Center to a nursing home or congregate setting with five or more individuals.	(Compliance) <u>Compliance</u>	<i>CIMs reviewed PST recommendations for individuals to be transferred to a nursing home or congregate settings of five or more individuals.</i>
IV.D.3	The Commonwealth will create five Regional Support Teams, each coordinated by the CIM. The Regional Support Teams shall be composed of professionals with expertise in serving individuals with developmental disabilities in the community, including individuals with complex behavioral and medical needs. Upon referral to it, the Regional Support Team shall work with the PST and CIM to review the case and resolve identified barriers. The Regional Support Team shall have the authority to recommend additional steps by the PST and/or CIM.	(Non Compliance) <u>Compliance</u>	<i>The Individual Services Review study found during the ninth period, that for 6 of 14 (42.9%) individuals referred to the RST, there was insufficient time for the CIM and RST to resolve identified barriers. Improvement was found during the twelfth review period when 2 of 2 (100%) individuals in the ISR study were referred timely and the reports showed that 92 referrals from Training Centers were on time.</i>

Settlement Agreement Reference	Provision	Rating	Comments
IV.D.4.	The CIM shall provide monthly reports to DBHDS Central Office regarding the types of placements to which individuals have been placed.	(Compliance) <u>Compliance</u>	<i>The CIMs provide monthly reports and the Commonwealth provides the aggregated information to the Reviewer and DOJ.</i>
V.	Quality and Risk Management	Compliance ratings for the ninth, eleventh, twelfth and thirteenth periods are presented as: (9 th period) 11 th period <u>12th period</u> 13 th period	<i>The Comments in <u>italics</u> below are from a prior period when the most recent compliance rating was determined.</i>
V.B.	The Commonwealth's Quality Management System shall: identify and address risks of harm; ensure the sufficiency, accessibility, and quality of services to meet individuals' needs in integrated settings; and collect and evaluate data to identify and respond to trends to ensure continuous quality improvement.	(Non Compliance) Non Compliance Non Compliance	This is an overarching provision of the Agreement. Compliance will not be achieved until the component sub-provisions in the Quality section are determined to be in compliance.
V.C.1	The Commonwealth shall require that all Training Centers, CSBs, and other community providers of residential and day services implement risk management processes, including establishment of uniform risk triggers and thresholds, that enable them to adequately address harms and risks of harm.	(Non Compliance) Non Compliance Non Compliance	The Commonwealth does not yet have a functioning risk management process that uses triggers and threshold data to identify individuals at risk or providers that pose risks.
V.C.2	The Commonwealth shall have and implement a real time, web-based incident reporting system and reporting protocol.	Compliance Compliance	DBHDS implemented a web-based incident reporting system. Providers report 87% of incidents within one day of the event. Some duplicate reports are submitted late.
V.C.3	The Commonwealth shall have and implement a process to investigate reports of suspected or alleged abuse, neglect, critical incidents, or deaths and identify remediation steps taken.	(Non Compliance) Non Compliance Compliance	DBHDS revised its licensing regulations, increased the number of investigators and supervisors, added expert investigation training, routinely includes double loop corrections in CAPs for immediate and sustainable change, and requires 45-day checks to confirm implementation of CAP's re: health and safety.

Settlement Agreement Reference	Provision	Rating	Comments
V.C.4	The Commonwealth shall offer guidance and training to providers on proactively identifying and addressing risks of harm, conducting root cause analysis, and developing and monitoring corrective actions.	(Non Compliance) Non Compliance Non Compliance	DBHDS has not yet completed the initial step of obtaining relevant and reliable data for the development of a QI/risk management framework. It has not finalized or disseminated “Draft Resource Tool to Develop a Provider Quality Improvement/Risk Management (QIRM) Framework.”
V.C.5	The Commonwealth shall conduct monthly mortality reviews for unexplained or unexpected deaths reported through its incident reporting system. The ...mortality review team ... shall have at least one member with the clinical experience to conduct mortality re who is otherwise independent of the State. Within ninety days of a death, the mortality review team shall: (a) review, or document the unavailability of: (i) medical records, including physician case notes and nurse’s notes, and all incident reports, for the three months preceding the individual’s death; ... (b) interview, as warranted, any persons having information regarding the individual’s care; and (c) prepare and deliver to the DBHDS Commissioner a report of deliberations, findings, and recommendations, if any. The team also shall collect and analyze mortality data to identify trends, patterns, and problems ... and implement quality improvement initiatives to reduce mortality rates to the fullest extent practicable.	(Non Compliance) Non Compliance Non Compliance	A Mortality Review Committee (MRC) has significantly improved its data collection, data analysis, and the quality of mortality reviews. It has begun a quality improvement program. The MRC rarely completed such reviews within 90 days. The newly recruited member, who is independent of the State, attended only 4 of 17 (24%) of the MRC meetings.
V.C.6	If the Training Center, CSBs, or other community provider fails to report harms and implement corrective actions, the Commonwealth shall take appropriate action with the provider.	(Non Compliance) Non Compliance Non Compliance	DBHDS cannot effectively use available mechanisms to sanction providers, beyond use of Corrective Action Plans. DBHDS is making progress by increasingly taking “appropriate action” with agencies which fail to report timely.

Settlement Agreement Reference	Provision	Rating	Comments
V.D.1	The Commonwealth's HCBS waivers shall operate in accordance with the Commonwealth's CMS-approved waiver quality improvement plan to ensure the needs of individuals enrolled in a waiver are met, that individuals have choice in all aspects of their selection of goals and supports, and that there are effective processes in place to monitor participant health and safety. The plan shall include evaluation of level of care; development and monitoring of individual service plans; assurance of qualified providers. Review of data shall occur at the local and State levels by the CSBs and DMAS/DBHDS, respectively.	(Non Compliance) Non Compliance Non Compliance	This is an overarching provision that requires effective quality improvement processes to be in place at the CSB and state level, including monitoring of participant health and safety.
V.D.2.a-d	The Commonwealth shall collect and analyze consistent, reliable data to improve the availability and accessibility of services for individuals in the target population and the quality of services offered to individuals receiving services under this Agreement.	(Non Compliance) Non Compliance Non Compliance	DBHDS continues to expand and improve its ability to collect and analyze consistent, reliable data. Concerns remain with their reliability and availability. Data are not being used to identify trends, patterns, strengths and problems at the individual, service-delivery, and systemic levels or to analyze the quality of services, service gaps, or accessibility of services.
V.D.3.a-h	The Commonwealth shall begin collecting and analyzing reliable data about individuals receiving services under this Agreement selected from the following areas in State Fiscal Year 2012 and will ensure reliable data are collected and analyzed from each of these areas by June 30, 2014. Multiple types of sources (e.g., providers, case managers, licensing, risk management, Quality Service Reviews) can provide data in each area, though any individual type of source need not provide data in every area (as specified):	(Non Compliance) Non Compliance Non Compliance	DBHDS staff proposed draft measures for a portion of the eight domains. However, the draft measures required significant additional work to collect valid and reliable data. Sources of data were not defined, which is an important step toward providing reliable data.

Settlement Agreement Reference	Provision	Rating	Comments
V.D.4	The Commonwealth shall collect and analyze data from available sources, including the risk management system described in V.C. above, those sources described in Sections V.E-G and I below (e.g. providers, case managers, Quality Service Reviews, and licensing), Quality Service Reviews, the crisis system, service and discharge plans from the Training Centers, service plans for individuals receiving waiver services, Regional Support Teams, and CIMs.	(Non Compliance) Non Compliance Non Compliance	This is an overarching provision. It will be nce until reliable data are provided from all the sources listed and cited by reference in V.C. and in V.E-G.
V.D.5	The Commonwealth shall implement Regional Quality Councils (RQCs) that shall be responsible for assessing relevant data, identifying trends, and recommending responsive actions in their respective Regions of the Commonwealth.	(Non Compliance) Non Compliance Non Compliance	DBHDS shared and RQCs reviewed data including: employment, OLS, OHR, and other data. The RQCs, however, had limited and frequently unreliable data available for review. See comment re: V.D.5.b. below.
V.D.5.a	The Councils shall include individuals experienced in data analysis, residential and other providers, CSBs, individuals receiving services, and families, and may include other relevant stakeholders.	(Compliance) Compliance Compliance	The five Regional Quality Councils include all the required members.
V.D.5.b	Each Council shall meet on a quarterly basis to share regional data, trends, and monitoring efforts and plan and recommend regional quality improvement initiatives. The work of the Regional Quality Councils shall be directed by a DBHDS quality improvement committee.	(Non Compliance) Non Compliance Non Compliance	The RQCs met quarterly, but had limited discussion. Their use of relevant data and analysis to identify trends and to recommend responsive actions, however, remains in its infancy. The DBHDS Quality Improvement Committee directed the RQCs work.
V.D.6	At least annually, the Commonwealth shall report publically, through new or existing mechanisms, on the availability ... and quality of supports and services in the community and gaps in services, and shall make recommendations for improvement.	(Non Compliance) Non Compliance Non Compliance	DBHDS expected that its restructured website would be available for public reporting after March 2018, but it was not available in September 2018.
V.E.1	The Commonwealth shall require all providers (including Training Centers, CSBs, and other community providers) to develop and implement a quality improvement (“QI”) program including root cause analysis that is sufficient to identify and address significant issues.	(Non Compliance) Non Compliance Non Compliance	The Commonwealth has approved new Regulations that require providers to have QI programs, but it has not yet informed providers of the minimum requirements for complying with its revised Licensing regulations.

Settlement Agreement Reference	Provision	Rating	Comments
V.E.2	Within 12 months of the effective date of this Agreement, the Commonwealth shall develop measures that CSBs and other community providers are required to report to DBHDS on a regular basis, either through their risk management/critical incident reporting requirements or through their QI program.	(Non Compliance) Non Compliance Non Compliance	The Commonwealth requires providers to report deaths, serious injuries and allegations of abuse and neglect. DBHDS revised Licensing Regulations which require providers to have risk management and QI programs. The Commonwealth has not yet informed them of its expectations regarding the measures that CSBs and providers will be expected to report.
V.E.3	The Commonwealth shall use Quality Service Reviews and other mechanisms to assess the adequacy of providers' quality improvement strategies and shall provide technical assistance and other oversight to providers whose quality improvement strategies the Commonwealth determines to be inadequate.	(Non Compliance) Non Compliance	<i>The Commonwealth's contractor completed the second annual QSR process. There are problems with the validity of the contractor's tools and process and, therefore, with the reliability of data collected and the accuracy of the results.</i>
V.F.1	For individuals receiving case management services pursuant to this Agreement, the individual's case manager shall meet with the individual face-to-face on a regular basis and shall conduct regular visits to the individual's residence, as dictated by the individual's needs.	Compliance <u>Compliance</u> Compliance	The eleventh period case management study and the thirteenth ISR study found that 44 of the 47 case managers (93.6%) were in compliance with the required frequency of visits. DBHDS reported data that some CSBs are below target.
V.F.2	At these face-to-face meetings, the case manager shall: observe the individual and the individual's environment to assess for previously unidentified risks, injuries, needs, or other changes in status; assess the status of previously identified risks, injuries, needs, or other change in status; assess whether the individual's support plan is being implemented appropriately and remains appropriate for the individual; and ascertain whether supports and services are being implemented consistent with the individual's strengths and preferences and in the most integrated setting appropriate to the individual's needs....	(Non Compliance) Non Compliance	<i>The study of case management confirmed a high percent of discrepancies between the services individuals are receiving and those described in his/her ISP. All essential supports were not listed in the ISP. The behavioral supports study found that inadequacies in implementation of BSPs had not been identified, or corrective actions steps had not been taken.</i>

Settlement Agreement Reference	Provision	Rating	Comments
<u>V.F.3.a-f</u>	Within 12 months of the effective date of this Agreement, the individual's case manager shall meet with the individual face-to-face at least every 30 days, and at least one such visit every two months must be in the individual's place of residence, for any individuals (who meet specific criteria).	(Compliance) Compliance <u>Compliance</u>	<i>The ninth and twelfth studies found that 45 of 46 (97.8%) completed the required visits.</i>
<u>V.F.4</u>	Within 12 months from the effective date of this Agreement, the Commonwealth shall establish a mechanism to collect reliable data from the case managers on the number, type, and frequency of case manager contacts with the individual.	Non Compliance <u>Non Compliance</u>	<i>DBHDS does not yet have evidence at the policy level that it has reliable mechanisms to assess CSB compliance with their performance standards relative to case manager contacts.</i>
<u>V.F.5</u>	Within 24 months from the date of this Agreement, key indicators from the case manager's face-to-face visits with the individual, and the case manager's observation and assessments, shall be reported to the Commonwealth for its review and assessment of data. Reported key indicators shall capture information regarding both positive and negative outcomes for both health and safety and community integration and will be selected from the relevant domains listed in V.D.3.	Non Compliance <u>Non Compliance</u>	<i>DBHDS does not yet have evidence at the policy level that it has reliable mechanisms to capture case manager/support coordinator findings regarding the individuals they serve.</i>
<u>V.F.6</u>	The Commonwealth shall develop a statewide core competency-based training curriculum for case managers within 12 months of the effective date of this Agreement. This training shall be built on the principles of self-determination and person-centeredness.	Compliance	<i>The Commonwealth developed the curriculum with training modules that include the principles of self-determination. The modules are being updated.</i>
<u>V.G.1</u>	The Commonwealth shall conduct regular, unannounced licensing inspections of community providers serving individuals receiving services under this Agreement.	Compliance Compliance	OLS regularly conducts unannounced inspection of community providers.
<u>V.G.2.a-f</u>	Within 12 months of the effective date of this Agreement, the Commonwealth shall have and implement a process to conduct more frequent licensure inspections of community providers serving individuals ...	Compliance Compliance	OLS has maintained a licensing inspection process with more frequent inspections.

Settlement Agreement Reference	Provision	Rating	Comments
<u>V.G.3</u>	Within 12 months of the effective date of this Agreement, the Commonwealth shall ensure that the licensure process assesses the adequacy of the individualized supports and services provided to persons receiving services under this Agreement in each of the domains listed in Section V.D.3 above and that these data and assessments are reported to DBHDS.	Non Compliance <u>Non Compliance</u> Non Compliance	The DBHDS Licensing process does not include protocols that include assessing the adequacy of the individualized supports and services provided.
V.H.1	The Commonwealth shall have a statewide core competency-based training curriculum for all staff who provide services under this Agreement. The training shall include person-centered practices, community integration and self-determination awareness, and required elements of service training.	(Non Compliance) Non Compliance Non Compliance	The Commonwealth drafted and subsequently revised and improved direct support professional and supervisory competencies. To achieve compliance, it must inform providers of its expectations and the measurable criteria providers must meet. The thirteenth ISR study found that residential staff are not receiving competency-based training.
V.H.2	The Commonwealth shall ensure that the statewide training program includes adequate coaching and supervision of staff trainees. Coaches and supervisors must have demonstrated competency in providing the service they are coaching and supervising.	(Non Compliance) Non Compliance Non Compliance	Same as V.H.1 immediately above.
V.I.1.a-b	The Commonwealth shall use Quality Service Reviews (“QSRs”) to evaluate the quality of services at an individual, provider, and system-wide level and the extent to which services are provided in the most integrated setting appropriate to individuals’ needs and choice.	(Non Compliance) Non Compliance <u>Non Compliance</u>	<i>It was not possible to determine the reliability and validity of the data gathered or the effectiveness of the proposed QSR process when fully implemented.</i>
V.I.2	QSRs shall evaluate whether individuals’ needs are being identified and met through person-centered planning and thinking (including building on individuals’ strengths, preferences, and goals), whether services are being provided in the most integrated setting	(Non Compliance) Non Compliance <u>Non Compliance</u>	<i>Same as V.I.1. immediately above</i>

Settlement Agreement Reference	Provision	Rating	Comments
V.I.3	The Commonwealth shall ensure those conducting QSRs are adequately trained and a reasonable sample of look-behind QSRs are completed to validate the reliability of the QSR process.	(Non Compliance) Non Compliance	<i>The Commonwealth's contractor completed the second annual QSR process. There are problems with the validity of the contractor's tools and process and, therefore, with the reliability of data collected and the accuracy of the results.</i>
V.I.4	The Commonwealth shall conduct QSRs annually of a statistically significant sample of individuals receiving services under this Agreement.	(Compliance) Compliance	<i>The Commonwealth's contractor completed the second annual QSR process based on a statistically significant sample of individuals.</i>
VI	Independent Reviewer	Rating	Comment
<u>VI.D.</u>	Upon receipt of notification, the Commonwealth shall immediately report to the Independent Reviewer the death or serious injury resulting in ongoing medical care of any former resident of a Training Center. The Independent Reviewer shall forthwith review any such death or injury and report his findings to the Court in a special report, to be filed under seal with the, ... shared with Intervener's counsel.	Compliance <u>Compliance</u> Compliance	The DHBDS promptly reports to the IR. The IR, in collaboration with a nurse and independent consultants, completes his review and issues his Report to the Court and the Parties. DBHDS has established an internal working group to review and follow-up on the IR's recommendations.
IX	Implementation of the Agreement	Rating	Comment
<u>IX.C.</u>	The Commonwealth shall maintain sufficient records to document that the requirements of this Agreement are being properly implemented ...	Non Compliance <u>Non Compliance</u> Non Compliance	The Independent Reviewer has determined that the Commonwealth did not maintain sufficient records to document proper implementation of the provisions, including case management and competency-based training of all staff.

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

III. DISCUSSION OF COMPLIANCE FINDINGS

A. Methodology:

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

- Reviewing data and documentation produced by the Commonwealth in response to requests by the Independent Reviewer, his consultants and the Department of Justice;
- Discussing progress and challenges in regularly scheduled parties' meetings and in work sessions with Commonwealth officials;
- Examining and evaluating documentation of supports provided to individuals;
- Visiting sites, including individuals' homes and other programs; and
- Interviewing individuals, families, provider staff, and stakeholders.

During this, the thirteenth review period, the Independent Reviewer prioritized the following areas for review and evaluation:

- Community-based Services for Individuals with Intense Behavioral Needs;
- Crisis Services - Planning, Prevention Strategies and Supports;
- Integrated Day - Supported Employment;
- Regional Support Teams;
- Office of Licensing/Office of Human Rights Investigations;
- Mortality Review; and
- Quality, Risk Management, and Training.

The Independent Reviewer retained nine independent consultants to conduct the reviews and evaluations of these prioritized areas. For each study, the Independent Reviewer asked the Commonwealth to provide all records that document that it has properly implemented the related requirements of the Agreement. Information that was not provided for the studies is not considered in the consultants' reports or in the Independent Reviewer's findings and conclusions regarding the status of the Commonwealth fulfilling the requirements of the Agreement. The consultants' reports are included in the Appendices of this Report.

For the thirteenth time, the Independent Reviewer utilized his Individual Services Review study process to evaluate the status of services for a selected sample of individuals. By utilizing the same questions over several review periods, for different subgroups and in different geographic areas, the Independent Reviewer has identified findings that include positive outcomes and areas of concern. The size of the selected sample allows findings to generalize to the cohort (i.e. by studying twenty-nine individuals, findings can generalize to the cohort of forty-nine individuals with a ninety percent confidence factor). By reviewing these findings, the Independent Reviewer has identified and reported themes. For this Report, the Individual Services Review study focused on individuals with intense behavioral needs.

The other studies completed by the Independent Reviewer's consultants for this Report examined the status of the Commonwealth's progress toward achieving or sustaining compliance with specific prioritized provisions that were targeted for review and evaluation. The Independent Reviewer shared

with the Commonwealth the planned scope, methodology, site visits, document review, and/or interviews and requested any suggested refinements to the plans for the studies.

The Independent Reviewer's consultants reviewed the status of program development to ascertain whether the Commonwealth's initiatives had been implemented sufficiently for measurable results to be evident. The consultants conducted interviews with selected officials, staff at the State and local levels, workgroup members, providers, families and staff of individuals served, and/or other stakeholders. To determine the ratings of compliance, the Independent Reviewer considered information provided prior to October 15, 2018. This information included the findings and conclusions from the consultants' studies, the Individual Services Review study, the Commonwealth's planning and progress reports and documents, and other sources. The Independent Reviewer's compliance ratings are best understood by reviewing the comments in the Summary of Compliance table, the Findings section of this Report, and the consultant reports, which are included in the Appendices.

During the fourteenth review period, the Independent Reviewer will study the status of the Commonwealth's progress toward achieving compliance with most provisions that were not studied during the thirteenth period. These provisions include: Waiver Slots, Children living in Nursing Facilities and Large Private ICFs, the Individual and Family Support Program, Case Management Services and Monitoring, Crisis Services, Family Guidelines, and Family and Peer Programs, Independent Housing, Discharge Planning and Transition of Individuals from Training Centers.

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

B. Compliance Findings

1. Serving Individuals with Intense Behavioral Needs

The Individual Services Review study during the thirteenth period studied the service outcomes for forty-nine individuals with intense behavioral service needs. The cohort for this study was comprised of all the individuals who:

- live in community-based settings in Region I (northwest), Region III (southwest), or Region IV (central);
- have received HCBS waiver-funded services for at least one year;
- were placed in level seven (Intense Behavioral Support Needs) based on the results of their Support Intensity Scale assessments; and
- had a most recent new start date from April 1, 2018 through May 1, 2018.

Twenty-nine individuals were selected randomly from the list of forty-nine, which provides a ninety percent confidence factor that the study's findings can be generalized to the cohort. The themes that emerged from this Individual Services Review (ISR) study are reported below. Tables with the specific findings from the completed Monitoring Questionnaires that were completed as part of this study are included in Appendix A. The ISR Monitoring Questionnaires completed for each individual were provided to the Commonwealth under seal as they include private contact and health information. By

March 31, 2019, DBHDS will provide written responses to the issues that the independent ISR review teams identified related to the services for each individual. The next section of this Report to the Court, Behavioral Programming and Supports, includes the findings of a more in-depth study of a subset of nine of the twenty-nine individuals who were randomly selected for the ISR study.

Themes from the ISR Study of Individuals with Intense Behavioral Needs

Although there were individual exceptions, the ISR study identified themes regarding the positive outcomes and areas of concern:

Positive Outcomes:

Receiving HCBS Waiver slots and Waiver-funded services has significantly improved the quality of life for individuals with intense behavioral needs and their families.

Significantly more individuals lived in more integrated settings. Of the seventeen individuals who did not live in their own home, leased apartment, or family's home, five lived in sponsor homes with two or fewer individuals with IDD. Twelve individuals were living in group homes, ten (83.3%) of whom lived in settings with four or fewer individuals.

Overall, the individuals' support plans were current and were person-centered (i.e., individualized). Case Managers typically documented making the required onsite visits, including visits to the individuals' homes.

Residential staff were able to describe the individual's likes and dislikes, talents and contributions and what's important to and important for the individual, as well as the individual's health related needs and their role in ensuring the needs are met.

The families of an individual with intense behavioral needs who was living at home provided love, support and exhibited great strength to ensure their family member's health, safety and well-being.

There were many positive healthcare process outcomes for virtually all the individuals studied. All but one of the individuals had a physical exam within a year and their Primary Care Physicians' recommendations were implemented within the prescribed time frames. All individuals had physician ordered diagnostic consults completed as ordered and within the recommended time frame. All but two had their medical specialist's recommendations addressed/implemented within the timeframe recommended by the medical specialist.

Areas of concern:

Structured behavioral programming and supports were not provided to most of the individuals. These individuals displayed aggressive, dangerous, and disruptive behaviors that negatively impacted their quality of life and that disrupted their households and other community settings. The behavioral programming that was provided lacked the elements that are essential to, and expected of, adequate behavioral programming.

Staff at the group, sponsor, or family homes for twenty-three of twenty-eight (82.1%) individuals had not received competency-based training (i.e., training that provides knowledge of performance expectations and that requires staff to demonstrate the skills learned), as required by the Agreement.

Difficulty recruiting and retaining Direct Support Professionals (DSPs) to work with individuals who lived in their families' homes undermined the adequacy and continuity of needed and planned services. This difficulty is exacerbated when individuals exhibit challenging behaviors.

The process for acquiring supported employment was often very slow and ineffective for individuals who wanted to work and/or for those with no work history. For some, families reported multiple assessments but little progress. For individuals who did not have a work history, employment was not considered the first option, as required by the Commonwealth's Employment First policy. Case Managers typically did not develop goals for discussions with individuals and their Authorized Representatives to help them to better understand the options for, and paths to, achieving supported employment.

For Individuals who are prescribed psychotropic medications, a combination of concerns was again found that that could contribute to serious negative health consequences. At the residential settings where these medications were administered, there was a lack of documentation of informed consent, of the intended side-effects of the medications, and of whether the individuals' nurses or psychiatrists conduct monitoring using a standardized tool for the detection of tardive dyskinesia or digestive disorders that are often side effects of psychotropic medications.

Families and providers reported that the REACH mobile teams were unresponsive and unhelpful . Examples were provided of crisis calls not being responded to or not being responded to at the individuals' homes.

For many of the individuals studied, the Case Managers did not fulfill certain requirements of the Agreement, as follows:

- The outcomes in ISPs were not specific and measurable;
- A choice of Case Managers was not offered or was contingent on the Authorized Representative first expressing dissatisfaction with the current Case Manager's performance;
- Employment service goals were not developed and discussed;
- ISPs were not modified as necessary in response to major life events; and
- Case Managers did not identify that behavioral programming was not being appropriately implemented.

2. Behavioral Programming and Supports

The Independent Reviewer retained an independent consultant to study in greater depth the behavioral programming and supports for nine of the twenty-nine individuals with intensive behavioral needs who were randomly selected for the thirteenth Individual Services Review study. The consultant compared the behavioral programming and supports that were reported to be in place with generally accepted standards and practice recommendations with regard to the components of effective behavioral programming and supports.

These standard components included:

- Level of need (i.e., based on behaviors that are dangerous to self or others, disrupt the environment and negatively impact his/her quality of life and ability to learn new skills and gain independence);
- Functional Behavior Assessment (FBA);
- Behavioral Support Plan (BSP) that is developed and overseen by a qualified clinician;
- Behaviors targeted for decrease;
- Functionally equivalent behaviors targeted for increase;
- Care provider and staff training; and
- Ongoing data collection, including regular summary and analysis with revision as necessary.

The individuals sampled had significant maladaptive behaviors that were not under control. Specifically, of the nine individuals sampled:

- Nine (100%) engaged in behaviors that injured self or others;
- Nine (100%) engaged in behaviors that disrupted the environment;
- Six (67%) engaged in behaviors that impeded their ability to access a wide range of environments; and
- Six (67%) engaged in behaviors that impeded their abilities to learn new skills or generalize already learned skills.

The Individual Services Review study found that both families and residential programs were managing the selected individuals' behaviors in most situations. There were some very concerning exceptions that involved assault, property destruction, eloping, injury to self and others, police involvement, and admissions to psychiatric hospitals. Overall, there were very few examples of plans being implemented to eliminate and replace maladaptive behaviors, which is a central purpose of behavioral programming.

The following areas of concern were documented by the in-depth study of behavioral programming and supports for the subset of nine individuals. The methodology for completing this study included review of service documents, on-site visits with and observations of the individuals, and interviews with the individuals' care giver:

- Of these nine individuals, only four (44%) were receiving formal behavioral programming through Behavior Support Plans (BSPs) at the time of the on-site visit. Overall, eight (89%) of the individuals sampled appeared to demonstrate significant maladaptive behaviors that negatively impacted their quality of life and greater independence; all had significant maladaptive behaviors that had dangerous and disruptive consequences to these individuals and their households. Meeting these criteria is a strong indication that most of the nine individuals would likely benefit from positive behavioral or other therapeutic supports implemented within their homes or residential programs.
- Of the nine individuals reviewed, only three (33%) had a Functional Behavioral Assessment in their current residential setting. Four (44%) individuals had BSPs. However, only three (75%)

of the BSPs were current; only two (50%) individuals had BSPs that were currently being overseen by the author or by another qualified clinician.

- Only three (60%) of the eight individuals appeared to have had Functional Behavior Assessments (FBA) completed within their current settings. When closely examined, of the three FBAs, only two (66%) appeared to have been completed using descriptive methods consistent with generally accepted practice recommendations.
- Of the nine individuals sampled, four had BSPs. Upon examination, however, the prescribed behavioral programming appeared inadequate. For example, although all of the BSPs identified target behaviors for decrease, none (0%) of the BSPs clearly identified and operationally defined specific functionally equivalent replacement behaviors (FERB), which are generally considered necessary for efficient and effective behavioral programming; and none (0%) had data to be collected, summarized and reviewed to determine whether planned interventions are working.

Conclusions:

- Many of the individuals were not receiving formal behavioral supports (e.g., BSPs) to address unsafe and disruptive behaviors, as well as skill deficits; implementation of appropriate behavioral interventions would likely improve their independence and quality of life.
- Most of the individuals identified as receiving formal behavioral supports did not have adequate functional behavioral assessments and their behavioral programming did not meet standards of generally accepted practice.

3. Crisis Services - In-Home Planning, Prevention and Supports

During the thirteenth period, the Independent Reviewer focused monitoring on the Commonwealth's Regional mobile crisis teams' provision of crisis planning, prevention strategies, and short-term crisis supports in individuals' homes. An independent consultant conducted a qualitative review of the Commonwealth's Regional Educational Assessment Crisis Response (REACH) delivery of community-based crisis services for forty individuals. The criteria for being included in the study were:

- children or adult with a diagnosis of IDD;
- living in DBHDS Regions I, II or V; and
- not hospitalized*, but received REACH services between April 1, 2018 - July 31, 2018.

*Note: Some of the individuals whose in-home services were studied were subsequently hospitalized after July 31, 2018.

The consultant's study reviewed the effectiveness of the REACH programs and community behavioral, psychiatric and psychological supports to de-escalate and prevent crises; to stabilize individuals who experience a crisis; and to provide successful in-home and out-of-home supports. Such supports include linking individuals to ongoing community services and supports that assist individuals to retain their community residential settings.

From the sixty children and adults who met the criteria described above, forty were selected by the consultant to create a stratified sample. Twenty-eight lived with their families including all fifteen of the children and thirteen of the twenty-five adults. The other adults lived in homes of residential providers. Sixteen of the individuals studied, fifteen of the twenty-five adults and one of the children, had waiver-funded services. The other twenty-four individuals did not have waiver slots to provide funding for therapeutic consultation and other services, including behavioral supports. Of the twenty-five adults, a majority (15) have co-occurring ID and mental health (MH) diagnoses. Nine of the adults have Autism Spectrum Disorder (ASD) as do twelve of the fifteen children.

The study included reviewing standard reports and records maintained by REACH and the Commonwealth, as well as interviews with REACH team members and Case Managers.

The purpose of the record review and the interviews was to gather information to:

- analyze the Commonwealth's efforts to provide crisis intervention and prevention services to help individuals avoid hospitalization and maintain their community settings;
- determine whether REACH responded to these crises in a timely way, completed required plans, and coordinated effectively with families, providers and case managers; and
- determine whether the community-based services system offered the necessary community supports that these individuals need in addition to REACH in order to continue to reside in their current residences.

The analysis included a review of REACH's crisis response; whether hospitalization was avoided as a result; the provision of in-home mobile supports; the development of the crisis plan; the development of community linkages for the individual; the availability of psychiatrists and behavior specialists; the provider capacity and whether the individual retained his or her provider.

REACH Crisis Response

Thirty-five of the forty initial calls to REACH in this review period were placed during an active crisis resulting from behaviors that involved physical aggression, property destruction and/or extreme self-injurious behavior, including suicide ideation or threats. REACH responded at the person's home in twenty (50%) of these calls and to the hospital to meet the individual in sixteen of the calls (40%). When able to respond to the individual's home, REACH and/or the police were able to stabilize the situation without the necessity of a hospital screening. In all twenty situations in which REACH did respond in the home, the crisis was stabilized and the individual was not removed. This is very significant. In establishing crisis intervention and prevention services, the Commonwealth envisioned, and committed to, responding to crises at the individuals' homes or relevant community setting. We know from past reports that this has frequently not occurred because the CSB Emergency Services (ES) screeners encouraged meetings at the hospital since they do not respond to a person at their home; often REACH has not been contacted until an individual is on the way to the hospital.

REACH's response times for thirty-six of the forty calls were well within the established guidelines, as required by the Agreement. There were four calls (10%) for children that were not responded to—one in Region I and three in Region II. Fortunately, none of these children were hospitalized.

Providing In-home Mobile Supports

REACH teams offered in-home mobile supports to all of the individuals in the selected sample and provided them to all who accepted REACH services. Timeframes for the supports ranged from a low of one hour to a high of eleven days. It is notable that the eleven days of mobile support to one individual are associated with a very difficult case and an excellent outcome that improved the quality of life for the child and family.

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

Although the study found some concerns with the objectives and progress notes related to the plans for the mobile supports, overall, the REACH Teams met the requirements and have achieved compliance with Section III.C.6.b.ii.E.

Crisis Education and Prevention Plans (CEPP)

DBHDS expects REACH teams to complete CEPPs for all individuals who choose to use REACH services. The consultant found that CEPP's were developed or updated for twenty-nine of the individuals in the sample. CEPPs could not be done for five of the individuals who had either refused or discontinued REACH services before a CEPP could be completed. In one case, a behavioral services provider was brought in by REACH and, because of the existing behavioral support plan, it decided appropriately that a CEPP was not needed. Of the three Regions whose services were studied, Region II completed CEPPs for all of their selected individuals (100%); Region I provided CEPPs for eight of nine individuals (89%), and Region V provided CEPPs for seven of the twelve individuals (58.3%). Overall, twenty-nine of the thirty-five (83%) individuals in the sample who chose to use REACH services.

Community Linkages

One of REACH's primary prevention strategies is to help individuals, families, Case Managers and teams establish linkages with community services that will more comprehensively help individuals to stabilize and maintain this stability; retain their residential and day providers; be assisted to find employment; and access the on-going medical and clinical supports they need to live successfully in the community. Linkages were already in place for six of the individuals in the study. REACH did not, therefore, pursue linkages for these individuals. However, upon discussion with REACH or the Case Manager, it seems that three of these individuals would have benefited from a behavioral specialist. REACH recommended, and in many cases arranged, linkages for thirty of the remaining thirty-four individuals. These linkages included connections with CSBs and Case Managers; pursuing waiver eligibility; referrals to the Department of Aging and Rehabilitative Services (DARS) for employment support or to other services such as day programs, outpatient therapy, family counseling, mental health support, neurologists, psychiatrists, independent skill training; and accessing services for a family moving out of state. Overall, linkages were arranged for 88% of the individuals selected for this study. However, not all needed linkages were established. Some individuals did not have a waiver-slot and, therefore, waiver funding for needed services.

Behavioral Specialist

This continues to be the least available and most needed support to assist individuals, and their families, who have co-occurring conditions and present behavioral challenges. Only six of the forty individuals (15%) had the support of a behavioral specialist. A behavioral specialist was not needed for another eight individuals. One individual had a behaviorist scheduled to conduct the initial evaluation but the family has cancelled the appointment. Twenty-five of the thirty-two individuals in the sample (78%) were not accessing the services of a behavioral specialist, but needed this expertise. This is a significant area of unmet need for individuals with I/DD in Virginia. Twenty-four of the individuals studied did not have waiver slots and therefore waiver-funded therapeutic consultation services. In addition, some families are reluctant to invite others into their homes and may decline behavioral supports.

Provider Capacity

Six of the twelve (50%) adults in the study who lived in the homes of residential services providers were discharged from their group homes. The providers justified discharging these individuals because these group homes were not properly staffed or staff were not adequately trained to address their needs. In two cases, individuals were hospitalized because the providers refused to have them return to their group home. One provider was seeking a protective order against the individual. One additional individual was arrested and jailed due to starting a fire outside using an accelerant. He decompensated in jail and remains in the psychiatric hospital to which he was transferred. This provider is apparently willing to serve him again, but the original setting the provider chose for him and the inconsistency of staffing at that setting contributed to his crisis and arrest.

Not all of the services providers were willing to accept training from REACH, to follow the individual's CEPP, or to implement recommendations for linkages or improvements in the structure and expectations of the day programs. Some of the individuals had crises during the summer when they did not have structured or meaningful daytime activities. Ensuring the competency of provider staff and the capacity to effectively support individuals with significant behaviors remains a challenge for the Commonwealth. This lack of behavioral provider capacity makes it very difficult to successfully maintain individuals with DD and either behavioral or mental health challenges in their residential settings and their communities.

Overall, for the individuals reviewed for this study, REACH is accomplishing the intended goals of stabilization via mobile supports. REACH responds to crises in a timely way and generally provided extensive mobile in-home supports. REACH worked effectively with Case Managers and took responsibility to arrange community linkages seriously. The extensive cross systems work necessary in a few of these cases was exceptionally well done and had very positive results. The success could be more consistent and with less recidivism if a behavior specialist were available and in place for all who displayed that need. The Commonwealth should reevaluate its current status and its efforts to increase the number of behavioral specialists and determine what further steps should be taken to address the current lack of behavioral specialists and needed behavioral programming.

The Commonwealth remains Section III.C.6.b.ii.B. The CSB - ES continue the pre-Settlement Agreement practice of meeting individuals in crisis at the hospital or the CSB office. For those who remained home, two of the three Regions studied had completed fewer than eighty percent of the DBHDS expectations for Crisis Education and Prevention Plans.

The Commonwealth has sustained compliance with Section III.C.6.b.ii.E. by consistently offering and providing up to three days of mobile crisis supports and an additional three days when needed.

4. Integrated Day - Supported Employment

The Independent Reviewer retained the same consultant who completed previous reviews to again evaluate the Commonwealth's progress toward achieving the Agreement's requirements related to the provision of integrated day activities, including supported employment.

Policy, Plan, Organizational and Operational Requirements

As reported previously, the Commonwealth had achieved compliance with the requirement to develop an implementation plan to increase integrated day opportunities for the individuals in the target population, including supported employment, community volunteer and other integrated day activities. The Independent Reviewer also reported previously that the Commonwealth had achieved compliance with several of the provisions that comprise the foundation of the statewide and systemic effort to increase these opportunities and that it has consistently sustained compliance for more than five consecutive years.

These provisions include:

- reviewing and refining its implementation plan annually;
- maintaining its membership in the State Employment Leadership Network, which is now called the Employment First Advisory Group - EFAG;
- continuing a state Employment First policy;
- including that policy as a requirement in its CSB Performance Contract;
- employing an employment services coordinator to monitor implementation of employment first practices; and
- providing training throughout the Commonwealth.

The Agreement also requires that, "*employment services and goals must be developed and discussed at least annually through a person-centered planning process and included in ISPs.*" The Independent Reviewer has also reported previously that the Individual Services Review studies have consistently found that Case Managers rarely develop goals for their discussions with individuals and, where applicable, their Authorized Representatives during annual individual service planning sessions. The development of individualized employment goals, which is a specific requirement by the Agreement, are very helpful in educating individuals and their Authorized Representatives about the potential paths to group and individual supported employment. To sincerely consider employment as the first and priority services option, as required by the Commonwealth's Employment First policy, discussing such goals is especially important for individuals who have not had any, or have not had a positive, work history, and for those with challenging behaviors and medical needs. The development and discussion of potential goals prompts inquiry and can frequently resolve misunderstandings regarding the impact of supported employment on benefits and the new approaches to transportation. The Independent Reviewer has not found evidence that the Commonwealth has included in its plans, or taken any other actions, to ensure implementation of the required annual development of

employment goals. The Commonwealth does not currently gather data regarding the development of goals for discussions of employment.

With input from the EFAG, DBHDS assessed and has produced a report on the status of its progress achieving the five goals in its Fiscal Year 2016 – 2018 Employment Plan. The consultant’s full report with findings, analysis, conclusions and recommendations, as well as the highlights of the status report of the Employment Plan, as of June 30, 2018, is included in Appendix C.

The Commonwealth, with the contributions of many stakeholders, completed most of the actions in its plan. It expected that accomplishing its planned goals would significantly increase the number of individuals to become employed, and, therefore, that it would meet its employment targets for those with HCBS waiver-funded services. To achieve its goals, the Commonwealth implemented revised and new service definitions, modified payment rates, created provider incentives, generated meaningful and consistent data reporting, and provided initial training. These changes were developed and implemented with interagency collaboration, especially between DBHDS and DARS. These changes did result in significant increases in employment for citizens of Virginia with IDD, but the increase fell significantly below the employment targets that DBHDS set in 2014 for individuals with IDD with waiver-funded services.

Establishing Baselines and Targets to Increase Supported Employment

The Agreement requires that the Commonwealth’s plan shall establish the following annual baseline information for individuals receiving HCBS waiver-funded services:

- The number of individuals receiving supported employment;
- The length of time individuals maintain employment in integrated work settings;
- The amount of earning from supported employment;
- The number of individuals in pre-vocational services; and
- The time individuals remain in pre-vocational services.

In addition to setting the required employment targets for the *“number of individuals receiving HCBS waiver funded services”*, the Commonwealth also set employment targets for the larger group of all individuals with IDD who are receiving employment services through all Commonwealth funded programs. Both sets of targets include the number of individuals who enroll in supported employment in each year and the number who remain employed for at least 12 months.

Since 2014, DBHDS has worked in partnership with DARS to refine its data collection and to ensure data are reported by all of its Employment Service Organizations. In 2014, the initial response rate from Employment Service Organization (ESO) providers to the Commonwealth’s data gathering efforts was only 44%. Now and for the fifth consecutive six-month period, the DBHDS Semiannual Report on Employment, through June 30, 2018, includes data based on a 100% response rate from ESOs semi-annual report. DBHDS also continues to gather data from a second source for both Employment Reports, which helps make comparisons between reporting periods.

Comparing the much larger number of individuals with IDD, not only those with waiver-funded services, who were employed as of June 2017 to June 2018, shows that the number employed in:

- ISE increased by 462 from 2,630 to 3,092;

- GSE decreased by forty-eight from 1,176 to 1,128; and
- Sheltered Workshops decreased by ninety-seven from 1,054 to 957.

For the larger group, as of June 2018, an additional 414 individuals with IDD were in supported employment compared with a year earlier; and, the gain occurred in ISE. Note that Supported Employment occurs in integrated settings and, therefore, those employed in congregate Sheltered Workshops are not counted. The above numbers reflect the total number of individuals with IDD reported as employed across all employment programs, including the programs offered by DARS, as well as the number of individuals in HCBS waiver-funded employment services. For the smaller group, the subset of individuals with waiver-funded services, whose disabilities are on-average more significant, more of these individuals were also employed: 972 in June 2018, compared to 826 in June 2017, an increase of 146 (+17.7%) in Fiscal Year 2018.

Based on the 100% response rate from its ESOs, the Commonwealth reported the average hours worked, the length of time at the current job, and earnings from employment. It is very positive to continue to have data that include all individuals with IDD who are employed. The increase in individuals in ISE is particularly noteworthy in the year between June 2017 and June 2018.

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

Setting Employment Targets

In March 2014, DBHDS set the required employment targets (Table 1) for the smaller group, individuals with waiver-funded services who, overall, have more significant disabilities. During the past year, although the number of these individuals receiving employment services had increased, DBHDS's progress toward achieving its targets fell significantly short of its target for this reporting period. While 146 more individuals were participating in ISE and GSE waiver-funded services in June 2018 than one year earlier, this increase represented only 74.9% of, and 325 fewer individuals than, the target of 1297 individuals. Members of the EFAG anticipate the availability of transportation supports for employment related travel and benefits planning under the waiver during the fourteenth review period will result in an additional increase in the number of individuals employed.

On December 30, 2016, DBHDS set a target for the larger group that by June 30, 2019, 4,218 individuals would be employed in both ISE and GSE, This target is 25% of the total number of individuals with IDD between the ages of eighteen and sixty-four who are either on the waivers or on the waiting list (16,871). As of June 2017, 3,806 of these individuals were so employed, which was 23% of this total number. As of June 2018, 4,262 individuals were employed, which achieved one year earlier than the target goal that DBHDS set for June 2019.

When redesigning its HCBS waiver programs, the Commonwealth created Community Engagement Services to provide inclusive community-based day activities, rather than group day support, in congregate and segregated settings, which is consistent with the goals of the Agreement. Community Engagement was designed as an option for individuals who were not ready or interested in employment and to enhance the lives of individuals who participated in part-time employment. It was not intended to replace employment for individuals who are capable of and interested in working. DBHDS cites the advent of Community Engagement, and some individuals and Authorized Representatives choosing Community Engagement rather than employment, as a factor in fewer individuals choosing employment services. The Individual Services Review studies have found other potential contributing factors. In annual ISP meetings with individuals and their Authorized Representatives, Case Managers' notes do not indicate that goals were developed related to achieving job readiness skills required for different jobs and to practicable paths to achieve these skills and employment. There has been a lack of provider capacity to develop and operate supported employment programs for individuals with intense needs. Discussing achievable job readiness and other skill development goals is especially important for families who are resistant, often due to myths and misconceptions, to supporting employment as a viable option. These factors and their respective contributions to the slower than expected addition of more individuals being employed will need further analysis in future reporting periods to determine how initiatives can be initiated to increase the numbers of individuals receiving waiver-funded employment services. The Commonwealth has improvement initiatives underway to increase the quality and quantity of goal development and discussion related to employment services.

End of FY	ISE	GSE	Total
16	211	597	808
17	301	631	932
<i>18</i>	<i>566</i>	<i>731</i>	<i>1297</i>
19	830	831	1661
20	1095	931	2026
<i>Total Increase '16-'20</i>	<i>884</i>	<i>334</i>	<i>1218</i>

The Commonwealth also set a target for the percent of those employed who would retain their jobs. DBHDS established a target that 85% would retain their jobs for at least twelve months. Of the number of individuals who were employed in June 2017, 91% had retained their jobs twelve months later in June 2018, which exceeded the target goal set in 2014.

The Commonwealth has fulfilled the requirement for setting targets to meaningfully increase the number of individuals who enroll in supported employment each year. The Commonwealth, however, is not yet in compliance with Section III.C.7.b.i.B.2.a., as it has not sufficiently identified or addressed some of the systemic obstacles to increasing employment for individuals with waiver-funded services to achieve its employment targets. Although increased, the number employed is only 74.9% of the Commonwealth's employment target.

The Commonwealth has sustained compliance with Section III.C.7.b.i.B.2.b. by setting and exceeding its goal to have more than 85% of the total number of individuals who are in ISE to remain employed for 12 or more months.

The Plan for Increasing Opportunities for Integrated Day Activities

The Commonwealth is required “*To the greatest extent practicable ... provide individuals in the target population receiving services under the Agreement with integrated day opportunities, including supported employment.*” The Commonwealth developed the plan that was required. In addition, during this reporting period, DBHDS revised its Community Engagement Plan for Fiscal Year 2016 through Fiscal Year 2018, which includes status updates through the fourth quarter of Fiscal Year 2018. The Commonwealth’s lead primary initiative to create meaningful community-based activities was the redesign of HCBS waiver programs and the subsequent creation of new community-based options, Community Engagement and Community Coaching, and related services with new or revised funding rates.

To guide the implementation of these new services DBHDS developed, with the input of the Community Engagement Advisory Group (CEAG), a comprehensive Community Inclusion Policy. This policy sets the direction and clarifies the values of community inclusion for all individuals with IDD, regardless of its severity. This policy requires the involvement of both the DBHDS and the CSBs to:

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

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

The Commonwealth provided an update, as of June 2018, on its Community Engagement Plan, as revised in December 2015. Its updates on the status of each goal are included in Appendix C. It is important and notable, however, that there are currently 198 licensed provider locations of Community Engagement (non-center-based day) services, an increase of fifteen since the previous reporting period. There are 2,375 approved authorizations for individuals to receive Community Engagement, compared to 1,588 in June 2017, an increase of 787 (+50%). There are also 239 (+99%) approved authorizations for Community Coaching compared to 120 in June 2017.

The Commonwealth’s accomplishments to-date are substantial and impressive. The guidance from DBHDS and DMAS has been especially important and helpful, and it will become even more important as the participation in Community Engagement and Community Coaching continues to increase substantially over a short period of time. DBHDS needs data that provide information on the hours of involvement and the type of activities that are offered. During a period of rapid program growth, it is especially important that DBHDS can monitor the effectiveness of this program and the satisfaction of its participants. Its process with DMAS may achieve this goal. The likelihood of success will be enhanced with data to analyze.

Regional Quality Councils

The Agreement requires that DBHDS's Regional Quality Councils (RQCs) review data regarding the extent to which the employment targets identified in Section III.C.7.b. are being met. It also requires the RQCs to consult with providers and the SELN (now the EFAG) regarding the need to take additional measures to further enhance the services and to determine whether the targets should be adjusted upward. The RQC's met quarterly and were provided employment data. The RQCs met with DBHDS senior employment staff, who also serve on the SELN/EFAG, to hear and discuss presentations regarding the data included in the DBHDS semi-annual employment report. Some of the Councils had more in-depth discussions and also made recommendations. The RQCs also discussed progress achieving the employment targets. Each of the RQCs have had challenges achieving consistent attendance at one or more meetings during the reporting period.

The Commonwealth maintained compliance with Sections III.C.7.c and d.

5. Regional Support Teams

The Independent Reviewer's consultant completed his fourth study of the Commonwealth's status in fulfilling the Regional Support Team (RST) requirements of the Agreement. The Agreement's provisions related to the RSTs are specific and measurable. The purpose and role of the RSTs is clearly defined, as are the roles and responsibilities for Case Managers and Community Resource Consultants (CRCs), whose performance is essential to the effectiveness of the RSTs. In his previous assessment of the status of the RSTs' functioning during Fiscal Year 2017, the consultant found that to function effectively the RSTs depend, at a minimum, on Case Managers submitting referrals to the CRCs to allow the RSTs sufficient time to review them prior to individuals being placed in large congregate settings. Each late referral largely nullifies the purpose of the RST for that individual. RSTs reported receiving referrals "too late" for between two and five out of every ten individuals throughout Fiscal Year 2017.

The consultant found both in his previous review and in his recent study that Case Managers continue to submit RST referrals late (after or concurrent with the individual's move) at approximately the same rate as previously. During the past year, in order to improve the efficiency and effectiveness of the RST process, DBHDS planned, with the input of CSB staff, and implemented multiple significant process improvements. Despite these efforts and the improved rates of timely submission of referrals in two Regions, the overall rate of late, and therefore ineffectual, referrals did not appear to improve. Since Fiscal Year 2013, some CSBs have appeared to ignore the Commonwealth's requirement to submit the required referrals timely to the RSTs. This pattern may have continued, at least in part, because there are no consequences to CSBs for not fulfilling the Commonwealth's directive to submit timely referrals. In addition to a late referral nullifying the value of the RST process for the individual, RSTs are not able to determine whether they would have been able to resolve any obstacles to more integrated residential options and, therefore, to determine whether there are gaps in services. Late referrals prevent the RSTs from learning what service gaps must be addressed. Although, DBHDS is now receiving data on late RST referrals broken down by Region or CSB, such data were not available for the thirteenth period. Therefore, it was not possible for the consultant to determine how many and which CSBs perform consistently and substantially below expectations.

It is important to note that when Case Managers submit timely referrals, the RSTs frequently succeed at their core functions, which are to:

- Identify, address and resolve barriers and ensure placement in the most integrated setting;
- Redirect individuals to more integrated settings prior to placements in nursing homes, intermediate care facilities and other larger congregate settings of five or more individuals; and
- Promote quality improvements in discharge planning and the development of community-based services.

When RSTs have received referrals with sufficient time to fulfill their core functions, one of the most frequent reasons that individuals and their Authorized Representatives choose more congregate settings is because they are available in their home communities, whereas there is an absence of more integrated settings. The lack of more integrated models of services is more pronounced for individuals with intense medical and behavioral needs. It is noteworthy that the ISR study has repeatedly found that the small sponsor homes reviewed have provided quality supports and the individuals served are often more involved in their communities.

During the past year, DBHDS generated a statewide approach to addressing service gaps and new slot development, which includes geo-mapping and self-calculating data displays. This provider development strategy is designed to respond to the Agreement's expectation: *The State shall ensure that information about barriers ... is aggregated and analyzed for ongoing quality improvement, discharge planning, and development of community-based services. (IV.B.14)* This approach, which was developed and implemented out of the DBHDS Division of Developmental Services' (DDS) Provider Development Section, makes data and startup funding available by Region to providers willing to grow the system's most integrated services. The overall strategy, the mapping tools down to region, county, or city, and the funding have been competently designed and, when the results are assessed, may represent a best practice strategy.

The Commonwealth created both CRCs and RSTs by the first quarter of 2013. The CRCs and RSTs exist in each Region and perform the functions described in Section III.E.1-3, with which the Commonwealth remains in compliance.

Findings from the review found that the overhaul of the RST process during this review period has the potential to have positive impacts on the system. However, for the RST system to work effectively, CSBs must submit timely referrals to the RSTs as required. The continuing failure of some CSBs to submit a high percentage of the required timely referrals undermines the Commonwealth's ability to fulfill this provision of the Agreement. In general, individuals who were referred in a timely manner to the RST tended to be placed in more integrated settings.

The Commonwealth is in non-compliance with Section III.D.6. The Commonwealth has sustained compliance with Sections III.E.1-3.

6. Office of Licensing and Office of Human Rights Requirements

During the thirteenth review period, the Independent Reviewer retained an independent consultant to complete his fifth annual review of the Office of Licensing (OL) and his fourth review of the Office of Human Rights (OHR) in order to assess the status of the Commonwealth's compliance with the Agreement's Quality and Risk Management provisions related to licensing and human rights investigations. These entities represent the Commonwealth's primary system for ensuring the health, safety and wellbeing of individuals receiving services. Therefore, the effective functioning of OL and OHR in accordance with the requirements of the Agreement is central to the goal of improving the lives of people with IDD in Virginia.

In his review one year ago, this consultant again found that the Commonwealth's licensing regulations did not align with the requirements of the Agreement, that draft revised licensing regulations showed an improved alignment with most of the provisions of the Agreement, including a clarification of expectations around root cause analysis, risk triggers and thresholds, risk management programs and quality improvement programs. However, the draft did not include criteria for several Agreement requirements, including "assessment of the adequacy of individual supports and services." In addition, the checklist used by OL to operationalize the requirements of the Agreement did not include assessment of the "adequacy of individualized supports and services." In addition, this checklist is documentation-focused, rather than outcome-focused, and does not include specific probes of the following Case Management requirements: identifying risks to the individual, offering choice among providers (including for Case Management), assembling professionals and non-professionals who provide supports, and amending the ISP when needed.

The last review found that DBHDS has made several important improvements in the effective function of OL and in OHR. New Regional Manager positions had been established by OL and had been incorporated into its operating protocols. Improvements were already apparent including refinements in investigation findings and in increased frequency of citations of CSBs and required corrective action plans (CAPs) related to Case Management performance problems and of citations for late reporting of serious incidents and deaths. OL and OHR had also improved their oversight mechanisms. At that time, the Independent Reviewer's studies of individual services and Case Management found several problem areas in CSB performance related to case management functions. However, the documentation provided by the Commonwealth did not indicate that the enforcement mechanisms included in the Commonwealth's performance contracts with the CSBs had been utilized to make progress toward fulfilling the requirements of the Agreement.

In his most recent report (attached at Appendix F), the consultant confirmed that the Governor had approved revised emergency DBHDS Licensing regulations for implementation in September 2018. The final draft changed language in at least sixteen areas: revised incident reporting requirements, clarified licensing statuses, updated DD and ID definitions, added requirements for providers regarding data sharing, upgraded risk management programs (including root cause analysis, monitoring reports, death reviews), quality improvement programs, and ISP (Individual Support Plan) requirements. The revised Regulations also include a partial assessment of the "adequacy of individualized supports and services" (Settlement Agreement, V.D.3); Table 2 below attempts to show the alignment of this section of the Agreement and the revisions.

Table 2
Agreement Alignment with Regulations:
Assessing Adequacy of Supports

Settlement Agreement: V.D.3		12VAC35-105-
a	Safety and freedom from harm	1240-12
b	Physical, mental and behavioral health and well-being	1240-11
c	Avoiding crises	--
d	Stability	--
e	Choice and self-determination	1245-iv
f	Community inclusion	1240-1
g	Access to services	--
h	Provider capacity	--

OL training and orientation to the new regulations began this past summer. All day training for Licensing Specialists, webinars for providers followed by Q and A sessions, creation of an FAQ (Frequently Asked Questions) for distribution, and follow-up provision of technical assistance by OL’s Regional Managers were all planned for late summer and autumn as part of the rollout of the major regulatory changes in the revised regulations. A non-citation grace period, until January 2019, is also planned to allow for familiarization and to determine additional needed technical assistance. To assist with this transition, DBHDS has also prepared documents including summary crosswalks between the outgoing and revised regulations, power point presentations, and guidance documents for Serious Incident Reporting and Quality Improvement Programs.

Other improvements found during the recent review included OL regularly compiling reports of compliance patterns and trends across provider agencies, including improved timely reporting of serious incidents. A sample of reviewed CAPs showed that Licensing Specialists appear to be consistently requiring double loop corrective action by providers; that is, expecting providers to correct the immediate citation or circumstance and to also establish processes to ensure this type of citation or circumstance is less likely to occur going forward. This review found that more providers appear to have used a root cause analysis approach to corrective action planning. A few providers also escalated their corrective actions for repeatedly late reports by disciplining (as opposed to re-training) employees. OL data for 2018 showed that only one provider was placed on provisional status; it also continued to show a significant number of providers deciding to voluntarily close settings. Some of these decisions are clearly in response to citations by Licensing Specialists and the providers’ inability to submit corrective action plans that are acceptable to OL. There is no evidence to contraindicate the view that there is a continuing systemic reluctance by DBHDS to pursue the use of corrective tools at their disposal. The heavy due process burden placed on Licensing Specialists may be the source of this reluctance to consider taking corrective actions beyond CAPs. Regardless of the rationale, OL has failed to use all the tools that it has available for sanctioning providers, which results in marginal providers continuing to operate services. It is doubtful that the paths of using provisional status and provider self-selection to close settings are sufficient for effective management of the problems of the minority of providers who deliver services that do not consistently meet standards.

As previously reported, provider and case management checklists used by OL do not include a full assessment of the “adequacy of individualized supports and services,” which is specifically required by

the Agreement. Current checklists are documentation-focused rather than outcome-focused and do not include specific probes of the adequacy of services. Examples of missing assessment probes for providers include the availability or quality of needed services, service gaps and delays. For case management, the missing probes include identifying risks to the individual, assembling professionals and non-professionals who provide supports, and amending the ISP when needed. However, it is important to note that some provider and case management agencies have been assessed and cited for one or more of these areas of concern.

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

The consultant reported in his last review that OHR had initiated, as a quality improvement strategy, retrospective look-behinds of a sample of provider investigations from closed cases. OHR continues these sampling reviews and was able to generate 360 case reviews distributed across five Regions in the past year. These latest reviews included a planned inter-rater reliability assessment component. Technical assistance efforts to improve the quality of provider investigations are provided by the OHR regional advocates at the time of the look-behind. The OHR look-behind is a well-done focus review that results in, and includes, Action Plans based on OHR findings.

The consultant previously reported that prior to the thirteenth review period the OHR retrospective reviews typically occurred six to twelve months following an investigation, suggesting the possibility that the information and feedback to the provider agency may be stale, investigative personnel may have changed, or direct support staff may have turned over. During the thirteenth period, OHR began completing these reviews quarterly. Although a small sample, the two agency investigators, who were interviewed for this study, reported that the technical assistance that they received relative to the cases OHR reviewed was helpful. These investigators were also found to be well-trained and well-organized related to their investigations.

In the most recent *Look-Behind Report* (March 2018), OHR noted that, against their own 86% benchmark, problems were identified in: timely reporting of CHRIS incident reports, documentation of interviews/witness statements, evidence of action taken by the provider, documentation that investigation findings were shared with the individual or Authorized Representative, and the absence of recorded formal training of investigators. To address these and other operational issues, OHR revised the “New Provider On-Boarding” process to include review of OHR policies, developed guidance documents for use by OHR staff when providing technical assistance, generated a Decision Tree, published a Complaint Resolution process map, revised their interagency protocol with the Department of Social Services on referrals and joint investigations, and updated protocols with OL regarding rights violations.

DBHDS contracted with a well-known national vendor of investigator training, Labor Relations Alternatives (LRA). The contract was limited to OL, OHR and other state staff. Twenty-one OHR staff were trained. There is no plan for private sector or CSB provider investigator training; however, there appear to be multiple learning opportunities either through self-instruction or classroom training for provider agencies’ investigators.

The Commonwealth remains in non-compliance III.C.5.d, the requirement to have a mechanism to monitor CSB compliance with Case Management performance standards. Licensing remains the Commonwealth's primary mechanism for monitoring such performance and its protocols do not include a review of the adequacy of case management services.

The Commonwealth is in compliance with V.C.2.

The Commonwealth has newly achieved compliance with V.C.3. Compliance was achieved as a result of the Commonwealth revising its licensing regulations, increasing supervision within OL and OHR, establishing standard CAP implementation confirmation checks and human rights look-behind processes, including double loop corrective actions designed to address immediate and long-term improvements, and increasing training of investigators.

DBHDS remains in non-compliance with V.C.6. Although DBHDS has increased taking "appropriate action" with agencies which fail to timely report, it does not use the sanction tools it has available to ensure that providers consistently meet standards or effectively implement CAPs.

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

DBHDS continues to be in non-compliance with the requirements of Section V.G.3. The DBHDS licensing process does not include the assessment of the adequacy of services in the eight domains at Section V.D.3.

7. *Mortality Review*

The Independent Reviewer again retained the same independent consultant to complete his third study to assess the status, as of September 1, 2018, of the Commonwealth's progress related to the Mortality Review requirements of the Agreement. The assessment included review of the Commonwealth's planning, development, and implementation of the Mortality Review Committee's membership, process, documentation, reports, and quality improvement initiatives. Details of the consultant's findings, analysis and conclusions are included in Appendix G.

When the consultant reviewed the status of the Commonwealth's compliance with the mortality review provisions during the eleventh review period, he reported that the Mortality Review Committee was implementing a new operating procedure that involved "initiating the reviews within ninety days" and "meeting as often as necessary" to eliminate the back log of needed mortality reviews. At that time, the MRC was also reviewing more death certificates, instituting a much-improved mortality review process, and tracking implementation of its recommendations. Compared with the status of the MRC in 2016, the MRC processes that were in place in the fall of 2017 appeared to be more efficient and effective and to be improving the quality and outcomes of the mortality reviews.

Although the Commonwealth had improved its MRC processes, it was not fulfilling the specific requirements of the Agreement. Reviews were rarely being completed within ninety days and the MRC did not have a member with clinical experience who was independent of the State to conduct reviews. It also did not have a process in place to rapidly review unexpected deaths to determine whether inadequately delivered supports or neglect might have contributed, and, if so, to ensure DBHDS reviews whether the individual's housemates might also be at risk. For example, when an individual,

who is prone to constipation and whose bowel movements were not properly monitored, dies as the result of a bowel blockage, it is highly likely that housemates with chronic constipation also may be at risk. The lack of a rapid review process prevents DBHDS from identifying a risk to others and, therefore, reducing mortality rates to the fullest extent practicable.

Data analysts had created systems to review the mortality data for completeness, accuracy and consistency. Each data field, however, was not defined and remained a challenge.

In the year since the previous review, the MRC instituted newly refined “Standard Operating Procedures for the DBHDS DD Mortality Review Committee” (dated June 12, 2018) and appointed an MRC Coordinator. These changes have improved the tracking and enhanced timeliness of obtaining and providing information for review by MRC members. The MRC’s creation and refinement of its Mortality Review Presentation Form has facilitated the presentation of available information for mortality reviews, which should increase the clinical value and quality of the reviews. During the past year, the MRC convened meetings every month, as required, and met more frequently, a minimum of two meetings per month. Member attendance has remained stable and new members (Office of Human Rights and psychopharmacology) participate who have specific expertise that will provide the MRC with additional insights and quality to the mortality review process. MRC has also continued to improve data collection and management. Overall, the MRC is completing better quality reviews with more information. As a result, it is categorizing fewer as “pending” and closing fewer when there is insufficient information.

The MRC membership and process, however, continues to not yet comply with the requirements of the Agreement. Long-standing and widely acknowledged shortcomings continue. None of 241 mortality reviews (see Table 3 below) were completed within the required ninety-day timeline. Following the departure of the DBHDS Medical Director and while recruiting a new M.D. Clinical Director, only nine of the thirty-two MRC meetings from April 26 through August 16, 2018 included a medical doctor; and, although DBHDS successfully recruited a member “with the clinical expertise to conduct mortality reviews who was otherwise independent of the State,” this independent nurse practitioner attended only four of seventeen (24%) MRC meetings. Without the participation of a medical doctor, the quality of a mortality review is challenged. In addition, the clinical value of having an independent member only results when that member attends and participates regularly in the MRC meetings.

Year	Within 90 days	Exceeds 90 days	% compliance
2014	123	103	54%
2015	71	216	24%
1/1/2016 - 6/30/2016	37	127	23%
7/1/2016 - 12/31/2016	1	107	1%
1/1/2017 - 3/31/2017	1	72	1%
4/1/2017 - 9/30/2017	1	64	2%
10/01/17 - 8/31/2018	0	241	0%

The MRC continues to lack a structure or process to rapidly review unexpected deaths by staff with appropriate clinical training and experience to identify safety issues that require action to reduce the risk of future adverse events and to reduce the rate of avoidable deaths. The Office of Licensing staff

are involved timely, but Licensing Specialists do not have clinical expertise or a clinical consultation process in place to complete a quality mortality review.

DBHDS's new Chief Clinical Officer has added a new initial review by the Chief Clinical Officer, who is a M.D., of the completed Mortality Review Presentation Forms to determine which deaths are "expected deaths." Such deaths are then given a streamlined mortality review compared with the full reviews of deaths categorized as "unexpected" or "unexplained." This streamlined review process is appropriate and will help focus more MRC time on mortality reviews of unexpected deaths and, hopefully, reduce the four to six-month backlog. The MRC may also need additional resources, however, to fulfill the Commonwealth's commitment to complete reviews within ninety days.

The MRC's full mortality reviews determine and categorize the cause of death as expected or unexpected, whether the death was potentially preventable and any recommendations or actions to address individual or systemic concerns. If the MRC cannot make these determinations and more information is needed, then the case is categorized as pending until further documents are reviewed by the MRC reviewer and presented to the MRC at a future meeting. If the cause of death differs between the death certificate and the MRC's conclusions, then the rationale for the MRC's determination is included in MRC minutes. The MRC typically reviews more information and devotes more time and with broader expertise when determining the likely cause of death and is, therefore, able to make better-informed determinations than the physicians who typically fill out and sign the death certificates.

After completing mortality reviews, the MRC makes recommendations based on its findings. At the time of this consultant's prior review, the MRC was testing a new tracking process for its recommendation entitled "Mortality Review Committee Action Tracking Report July-Sept 2017." At that time, the results indicated that all recommendations were being tracked until completion. The current study found that from July 2017 to August 2018, there were 125 MRC recommendations that had been tracked. As of September 2018, there were only ten pending recommendations (8%). Most of the remaining recommendations had been closed (80%) or did not need additional follow up. It was notable that fifty of these recommendations (40%) were systemic in nature with impact intended to improve the quality, efficiency, and/or effectiveness of the process, or with impact to improve quality of life, health, and safety of individuals with IDD. The tracking system indicates that there is now timely follow through of the recommendations until they are closed.

In March 2017, the MRC produced the 'Mortality Review Committee Quality Improvement Plan.' In November 2017, DBHDS reported progress with completion dates on three goals. Although it did not report progress having been made on five other goals, it indicated that DBHDS was taking actions to implement four of these five goals. In its third, and most recent, Annual Mortality Report for July 1, 2016 - June 30, 2017, DBHDS presented aggregated data regarding causes of death, causes of the "other" category of death, percent of deaths considered expected versus unexpected, use of hospice care, along with several other demographic indicators. The Annual Report also included updates on progress, or the lack of progress, of implementing recommendations from its Fiscal Year 2016 Annual Report. The QIC is planning to review the most recent Fiscal Year 2017 Annual Mortality Report during its upcoming quarterly meeting.

The DBHDS Office of Integrated Health Services (OIHS) continues to create Safety Alerts, which include subject matter that addresses issues that emerge from mortality reviews. The Alerts are distributed to service providers by email and are posted on the DBHDS website. OIHS also produces a monthly newsletter, which provides information on a wide variety of topics important to individuals

with IDD. The Alerts were found to be of high quality. They were written for easy understanding by the lay public and included source references. OIHS also created one page “in a nutshell” summaries of these Alerts. The revised Alerts are an indication of a quality improvement approach: the periodical review of past Safety Alerts to determine whether the guidance provided regarding implementation of policies and practices that address complex issues can be improved, and, if so, to make needed and then distribute revised and updated versions.

The “Mortality Tracker,” the MRC minutes, and the Mortality Review Presentation Form included valuable data that provide information concerning the most common causes of death. These data are aggregated in the Annual Mortality Report. The percentage of deaths from pneumonia and combined respiratory/pneumonia which had spiked significantly in the prior review period (33%), appears to have decreased during this review period (20.7%). The cause of death did not change significantly as a percentage of total deaths from prior review periods for cancer, aspiration, sepsis, GI, and neurological causes. MRC established and added “multiple medical” as a new Cause of Death category to the MRC tracking database. It is positive that, overall, the MRC’s unknown category of deaths has continued to decrease over time, from 20.8% in 2014 to 7.1%. It is important to note that areas of concern such as aspiration, choking, and sepsis have not been reduced significantly, despite Safety Alerts, training across the state by OIHS staff, and monthly newsletter articles. Reduction in the incidents of these causes of death, some of which are potentially avoidable, will require ongoing oversight regarding the adequacy and appropriateness of health and safety protocols and potentially new and additional approaches. However, through the thirteenth review period, the OIHS work to educate providers on the topics addressed by the Safety Alerts and Newsletters has been well done and helpful.

The MRC has continued to make important progress toward fulfilling the mortality review related requirements of the Agreement. To achieve compliance, however, the MRC must have all required members, including one with expertise to conduct mortality reviews who is independent of the State and who attends and participates regularly (i.e. 85%) in the MRC meetings. And, within ninety days of each unexpected death, Mortality Reviews must be completed and recommendations must be prepared and delivered to the Commissioner for actions to reduce mortality rates to the fullest extent practicable. To reduce risks, to reduce mortality rates, and to improve safety of housemates who are served, the Commonwealth must have a rapid review process of unexpected or unexplained deaths.

8. Quality and Risk Management

The Settlement Agreement requires the Commonwealth to develop and implement a Quality and Risk Management System that shall:

V.B. "... identify and address risks of harm; ensure the sufficiency, accessibility, and quality of services to meet individuals' needs in integrated settings; and collect and evaluate data to identify and respond to trends to ensure continuous quality improvement."

V.D.2 "... collect and analyze consistent, reliable data to improve the availability and accessibility of services for individuals in the target population and the quality of services offered to individuals receiving services under this Agreement."

V.H. "... have "a statewide core competency-based training curriculum for all staff who provide services under this Agreement. The training shall include person-centered practices, community integration and self-determination awareness, and required elements of service training."

The Independent Reviewer retained an independent consultant to assess the Commonwealth's progress toward meeting five discrete areas of Quality and Risk Management:

- Risk triggers and thresholds;
- Risk Guidance and Training;
- Data to assess and improve quality;
- Providers; and
- Training.

Although the Commonwealth is in the seventh year of implementing the provisions of the Agreement, its Quality and Risk Management initiatives in these five areas continue to be in the process of development and the beginning stages of implementation. As a result, as occurred in the 2017 review, the consultant's report (Appendix H) is based on a number of draft documents, in addition to interviews with staff from DBHDS, CSBs and provider agencies. Since this consultant's last review in 2017, the new Commissioner made changes to the DBHDS organizational structure, including the responsibilities for oversight and implementation of the Department's quality assurance (QA)/risk management and quality improvement (QI) functions.

In all these five areas, DBHDS has made some progress in preparing to describe the framework for how it will work with CSBs and providers implementing the elements of a Quality and Risk Management System. These descriptions are not yet final. DBHDS has not yet distributed the framework, nor has it established its related minimum expectations for CSBs and providers.

Risk Management - Triggers and Thresholds

As of the last review, the Commonwealth had stopped the development of lists of specific triggers and thresholds to identify and address risks of harm. It had decided to pursue different options for identifying individuals at risk of, or who had experienced, harm as well as the providers that might place individuals at risk. This represented a shift from planning a reactive system, which would have relied heavily on the Commonwealth to identify that a problem had occurred and notify CSBs and/or

providers, to planning a more proactive approach, which would depend on CSBs and providers, as well as Commonwealth staff, to proactively identify risk and the potential for risk. The Commonwealth anticipated that this revised system would also retroactively address harm that had already occurred in order to prevent its recurrence to the extent possible. As of the last Review, Commonwealth staff had drafted an initial framework for this new approach, but recognized that much more work was needed to finalize and implement the “Draft Community-Based Risk Management Framework.”

During the past year, DBHDS staff worked on several components of the “Draft Community-Based Risk Management Framework.” The document that describes each component remains in draft form. The components are not yet in use by CSBs and providers, but may be being piloted. For example, an updated “Incident Management Report” has been developed and is available that uses actual data, which has the potential to drill down into these data, (e.g. by Region, CSB, provider location, individual, type of incident, etc.). The DBHDS Computerized Human Rights Information System (CHRIS), which is in the process of being updated, is projected to include levels that reflect the severity of incidents that are reported. Once completed, DBHDS plans to review and make further changes to the Incident Management Report. Future steps for these reports will include using the data to determine trends, analyzing the data and trends, and using the results to effectuate change.

DBHDS expects to use annual health risk assessments to determine individuals’ risks in key health areas. At the time of this review, the Commonwealth has six Managed Care Organizations (MCO), each of which is using a different Health Risk Assessment (HRA) tool. DMAS and the MCOs are working to develop one standardized HRA or to use common elements that all six MCOs would include in different risk assessment tools. DBHDS has provided technical assistance to facilitate the CSBs’ Case Managers/Support Coordinators to collaborate and establish relationships with individuals’ Care Coordinators from whom they would request HRAs or the identified risks and to discuss plans to mitigate these risks. However, CSBs report having limited results obtaining information regarding individuals’ risks and plans to mitigate risk from the MCOs and Care Coordinators. CSBs attribute this variability to different levels of willingness among the MCOs to share information that they either consider proprietary or to be private health information that cannot be shared under the Health Insurance Portability and Accountability Act (HIPAA). DBHDS and DMAS are exploring next steps. DBHDS staff recognize that the risk assessment process is the first step in identifying risks of harm, and that significant additional work is required to address the risks that are identified. The risks identified must be included in the development and implementation of ISPs that address individuals’ risks in a clinically appropriate manner.

The Commonwealth does not yet have a functioning risk management process that uses triggers and threshold data to identify individuals at risk or providers that pose risks. Such processes are not yet in place to triage risk trigger and threshold data, to determine the highest priority issues to address first, or to ensure that the issues identified are being addressed. The Commonwealth remains in non-compliance with Section V.C.1.

Risk Management – Guidance and Training to Providers

DBHDS provided evidence of a number of initiatives that would lead to providing guidance and training to providers. For example, it continued to pursue a quality management rating system to measure the quality of services and supports offered by community-based providers. Updates during the thirteenth period did not illustrate progress on this project.

The Quality Improvement Committee and Regional Quality Councils reviewed some licensing citation data reports, but overall, the rating system has not yet been established; and work continues to determine the best ways to use these data to provide guidance to providers regarding the development of risk management and quality improvement systems.

DBHDS listed obtaining data as the first step in developing provider quality improvement programs and a QI/risk management framework. Once completed and implemented, the Commonwealth has proposed monitoring providers' and CSBs' implementation, and then reporting on specified metrics. Since the last review, DBHDS prepared the: "Draft Resource Tool to Develop a Provider Quality Improvement/Risk Management (QI/RM) Framework." This document describes the regulatory backdrop for risk management and quality improvement systems, and the provider leadership structure, strategies and processes to mitigate risk. Its appendix provides numerous references. The draft Framework, which has not yet been implemented, includes a compilation of important information about risk management systems. It also identifies a large array of potential resources that might assist providers to develop or refine their systems. Although not yet implemented, CSB representatives interviewed for the consultant's review expressed concerns that CSBs and providers, particularly those struggling to develop basic risk management systems, may be overwhelmed. This version of the document has not yet been finalized or disseminated. It may be amended or modified as new leadership at DBHDS considers supplemental or alternative approaches.

As past Reports indicated, the Commonwealth's licensing regulations have previously provided significant obstacles related to implementing risk management and quality improvement programs within provider agencies. The Commonwealth's approval of revised emergency Licensing Regulations for implementation in September 2018, the final month of the thirteenth review period, is an important positive accomplishment. These revised Regulations include requirements that, "the provider shall conduct systemic risk assessment reviews at least annually to identify and respond to practices, situations, and policies that could result in the risk of harm to individuals receiving services." The risk assessment reviews shall address:

- the environment of care;
- clinical assessment or reassessment processes;
- staff competence and adequacy of staffing;
- use of high-risk procedures, including seclusion and restraint; and
- a review of serious incidents.

This required risk management process must also "incorporate uniform risk triggers and thresholds as defined by the Department."

The revised Licensing Regulations also require the provider to develop and implement a quality improvement program (QIP) that is sufficient to identify, monitor, and evaluate clinical and service quality and effectiveness on a systematic and ongoing basis. The provider must:

- review and update the QIP at least annually;
- establish measurable goals and objectives;
- include and report on statewide performance measures;
- utilize standard quality improvement tools, including root cause analysis;
- regularly evaluate progress toward meeting established goals and objectives; and
- incorporate any corrective action plans.

The revised Regulations also require providers to provide the Commonwealth with reliable data from their fully implemented risk management and quality improvement programs. Demonstration of the effective implementation of these requirements is required to achieve compliance.

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

Data to Assess and Improve Quality

The consultant had previously reviewed the status of the Commonwealth's Quality Improvement Strategy, which was approved on September 1, 2016, when the federal Centers for Medicare and Medicaid Services (CMS) approved Virginia's amendments to redesign its HCBS waivers. The Quality Improvement Strategy outlines the basic assurances the Commonwealth agreed to provide to CMS to measure the quality provision of protections, services, and supports through the implementation of the waivers. These assurances include data and information regarding:

- Case Management;
- the inter-agency Quality Review Team;
- the DBHDS Quality Improvement Committee and Regional Quality Councils;
- Quality Services Reviews; and
- the DBHDS Mortality Review Committee.

The October 20, 2016, draft Quality Management plan presented a comprehensive, high-level description of how DBHDS structures its Management program. At that time, the consultant found that both the existing and the draft plans were not the central repository of DBHDS/DMAS efforts to advance the structure and implementation of a data-driven quality improvement system, did not provide a roadmap for DBHDS to expand and improve its ability to collect and analyze data to measure improvement, and had not yet been updated to incorporate some of the more recent modifications to the way in which DBHDS was collecting and analyzing data.

In the current review, the consultant found that Commonwealth had prepared a more recent document, dated July 2018, which is entitled: "DRAFT Virginia Department of Behavioral Health and Developmental Services (DBHDS) Quality Management Program." This draft is similar to the DBHDS Quality Management Plan of October 20, 2016. It also presents a high-level description of how the agency structures its Quality Management program. The document only briefly mentions the CMS waiver assurances in the context of DBHDS collecting, reviewing and analyzing data at the local and state levels to determine its compliance with external requirements. In addition, given the organizational structure changes that the Commissioner made in August 2018, the July draft will likely need to be updated to reflect the modified DBHDS administrative structure and the redistribution of responsibilities for conducting quality improvement activities.

In addition, the July 2018 draft provided a description of the program, but did not provide a plan or roadmap for DBHDS to expand and improve its ability to collect and analyze data to measure improvement in either the quantity or quality of its services for individuals in the target population. DBHDS should consider incorporating a roadmap (e.g., annual plan) as an attachment to the Quality Management Program and assure that the plan is kept up-to-date to reflect its most current plans and initiatives.

Collecting and Reviewing Reliable Data:

The Independent Reviewer reported in December 2017 that DBHDS’s “current efforts to identify, analyze and expand the use of data were appropriate first steps.” At that time, DBHDS had not yet developed a structured plan that includes specific goals, objectives, tasks and timelines to guide the efforts necessary to identify, define, collect, analyze, report, and effectively use relevant data to evaluate and improve services. Without a formal plan to establish the parameters, objectives, and timelines for the project, it was difficult to determine, whether externally or internally, if the efforts and resources DBHDS had dedicated to these initiatives were leading to meaningful progress. The Independent Reviewer recommended that “DBHDS create a comprehensive data quality improvement plan to provide a roadmap and specific milestones. This plan should guide its ongoing efforts to expand and improve the quantity and quality of data collected, and the Department’s effective use of data in its measurement of performance.”

In her recent review, the consultant again found that DBHDS continued to expand and improve its ability to collect and analyze consistent, reliable data. DBHDS staff have continued to harness some of the data that are currently available, including making licensing information more accessible and Quality Service Review data more accessible and user-friendly. However, there are still significant concerns with the reliability of data and available data are not being used to identify trends, patterns, strengths and problems at the individual, service-delivery, and systemic levels related to the quality of services, service gaps, accessibility of services, and serving individuals with complex needs.

As discussed above, it is also difficult internally for DBHDS, or for external reviewers, to determine the extent of progress, or the meaningfulness of changes, without a written plan that establishes the goals, objectives, milestones and timelines to expand and improve the effective use of data to guide the efforts necessary to identify, define, collect, analyze, report, and effectively use relevant data to evaluate the availability, accessibility and quality of services.

Reliable Data for the Eight Domains:

Since the review in 2017, DBHDS has made limited progress with regard to the development of the data-based report to measure progress in each of eight domains set out in Section V.D.3.

The last review determined that DBHDS had produced the “Report on the Eight Domains” in October 2017, which greatly expanded the set of twenty-six data measures for the eight Domains. While recognizing some of the limitations of the data currently available, DBHDS had done solid work in defining relevant measures for each domain. Although the Commonwealth had made progress, DBHDS staff recognized that the indicators in the eight domains were in their infancy. These initial indicators were only the first step in successfully implementing a much larger project.

In her recent review, the consultant found that, for a number of months, DBHDS’s development of additional indicators and measures had stalled. In the months prior to the recent review, DBHDS meeting notes reflected staff concerns with the slow pace and work picked up. Some draft measures were proposed for a portion of the eight domains. However, the draft measures required significant additional work to collect valid and reliable data. Sources of data were not defined, which is an important step toward providing reliable data. With few exceptions, baseline measurements were not provided. The development of valid and reliable measures is time-consuming, but essential to fulfill the requirements of this provision.

Regional Quality Councils:

Since the last review, the status of the Regional Quality Councils (RQCs) remains essentially the same. As reported previously, the five RQCs were implemented with the required membership and are operational. They consistently hold meetings each quarter in each of the five Regions. DBHDS staggered membership terms for each member to ensure consistency as members' terms expire. Minutes reviewed showed efforts to replace members as vacancies occurred. The work of the Regional Quality Councils is directed by DBHDS.

The RQCs' use of relevant data and analysis to identify trends and to recommend responsive actions, however, remains in its infancy. Continuing to focus RQC meetings around data analysis presentations will enhance the capabilities of each RQC to identify trends and issues and to make meaningful recommendations. The minutes do not indicate that the RQCs developed and made substantive recommendations to the QIC.

Public Reporting:

The Commonwealth is required, at least annually, to report publicly, through new or existing mechanisms, on the availability and quality of supports and services, on gaps in services, and to make recommendations for improvement. In the last Quality Report, the consultants reported that, due to changes with the DBHDS website, reports that the website previously included had been deleted. By March 2018, DBHDS anticipated that the annual report would be up and running. By September 2018, the time of the current review, the website was not yet operational.

To report to the public, DBHDS staff have compiled some existing reports that are ready to be uploaded to a website. Other reports or data need further refinement before they are also ready. Nothing has been, or will be, reported to the public, as required, until the website is operational.

The Commonwealth remains in non-compliance with Sections V.D.1-4 and 6. It is in compliance with Section V.D.5.a, but remains in non-compliance with V.D.5. and 5.b

Providers

The Agreement requires providers to monitor and evaluate service quality, and, in so doing, refers to the DBHDS Licensing Regulations. As reported above, in September 2018, the final month of the thirteenth review period, the Commonwealth approved revised emergency Licensing Regulations. These revised Regulations update and clarify the requirements with which providers must comply. Whereas the previous DBHDS licensing Regulations were vague and did not align with the specific requirements of the Agreement, the revisions clarify these requirements to align much more closely. The revised Regulations require providers to develop and implement the quality improvement programs (QIP) and provide a specific list of criteria that the required QIP must include, such as:

- Measurable goals and objectives;
- Statewide performance measures (as required by DBHDS);
- Utilize standard QIP tools, including root cause analysis;
- Incorporate any corrective action plans;
- Implement a process to regularly evaluate progress toward meeting goals and objectives; and
- Annual review and update.

In addition, the Commonwealth added QIP requirements to the draft Performance Contract with CSBs, beginning with Fiscal Years 2015 and 2016.

With approval for implementation in September, the final month of the thirteenth review period, although some internal work was underway, the Commonwealth had not yet established or communicated expectations for CSBs' and private providers' quality improvement programs. Although the Commonwealth took some important steps to provide technical assistance to CSBs, formal training to CSBs and private providers had not yet begun.

The Commonwealth did undertake a substantial undertaking to review aspects of all forty CSBs' data collection and reporting methodologies. In December 2017, DBHDS decided to review the CSBs' internal data to validate data and data reporting processes and to provide technical assistance and consultation to CSBs that were not meeting data reporting targets to assist in identifying and resolving data collection and reporting, as well as to facilitate root cause analysis of data reporting with CSB teams. Based on review of a sample of reports from these reviews, as well as the consultant's interviews with two CSBs, these efforts were extremely helpful in identifying problems impacting the collection of valid and reliable data, and in providing technical assistance to resolve identified issues. These issues included coding problems, confusion regarding outcome measures, issues with the numerous electronic health records used by different CSBs, and a need for improvement in Case Managers' ability to identify and monitor risks.

The Commonwealth has not yet informed providers or CSBs of the key indicators or the data that they will be required to report to DBHDS through their QI programs. As noted above and in the consultant's report at Appendix H, the Commonwealth made limited progress in finalizing drafts of the data that it intends to collect. In order to address the requirements of the Agreement, additional data will be required. In some cases, improvements also are needed in the reliability of the data that are currently being collected. In other cases, mechanisms and methodologies for collecting the data need to be developed.

Although it has taken a major step forward by revising its Licensing Regulations to align much more closely with the Agreement, the Commonwealth remains in non-compliance with Sections V.E.1-2.

Training

The Agreement requires the Commonwealth to have a statewide competency-based training curriculum for all staff on person-centered practices, community integration and self-determination awareness, and required elements of service. The statewide training programs must also ensure that coaches and supervisors have demonstrated competency in providing the services that they are coaching and supervising.

As reported previously, as of September 1, 2017, DBHDS had defined competencies for Direct Support Professionals (DSP) and Supervisors who support Individuals with Developmental Disabilities. In four documents, DBHDS defined basic, health, behavioral, and autism competencies. In her last review of Training, the consultant recommended that DBHDS simplify and streamline its requirements for providers. For the current review, DBHDS provided a "Draft DSP Competencies Checklist Template," dated August 28, 2018. For this document, DBHDS' goals were to simplify the

competencies to identify the minimal requirements that all DSPs must meet, to make them more measurable, and to replace the basic competencies document.

Overall, the changes provide simpler and more measurable competencies, which will be more likely to be implemented fully and consistently by providers. These changes:

- maintain the three overall competencies:
 - demonstrating person-centered skills, values, and attributes;
 - understanding and following service requirements; and
 - demonstrating abilities that improve or maintain the health and wellness of those they support;
- significantly reduce the number of specific competencies;
- add observation indicators that provide more descriptions of observable actions or activities to demonstrate competency; and
- allow supervisors to document a staff member's progress and check-off final proficiency.

The consultant has offered suggestions (Appendix H) to improve important competencies that were lost when the number was reduced, to ensure the measurability of the competencies to verify that staff deemed proficient can actually demonstrate the competencies, and to ensure that external monitors can reliably measure compliance with the competency-based training requirements. It is the Independent Reviewer's informed opinion that more evidence than a check mark is needed to verify that proficiency has been achieved. The Independent Reviewer's studies have found many examples of boxes being checked without the task in question having been completed.

The Commonwealth's emergency Regulations related to the implementation of the HCBS waiver redesign, which were in effect from September 1, 2016 through February 28, 2018, specified detailed requirements for competency-based training. The newly revised DBHDS emergency Licensing Regulations provide much less specific requirements. The Commonwealth should share with providers its guidelines and expectations. It should note specifically that all staff must receive competency-based training that includes requirements that staff demonstrate competency related to the performance expectations taught regarding the elements of the individual services provided.

The Commonwealth staff indicated that DBHDS licensing reviews would be a primary way to assess providers' compliance with training requirements. To achieve compliance, it will be important for the Commonwealth to inform providers of the guidelines and expectations that its Licensing staff will utilize to determine whether provider training processes and outcomes are sufficient. The Commonwealth committed in the Agreement that the training for *all staff who provide services under the Agreement and their supervisors be competency-based* (i.e. completion of the training requires demonstrating the competency in the performance expectations and skills taught).

This requirement of the Agreement, that all staff will be trained to be competent in the element of service that they are implementing, is fundamental to ensuring the provision of consistently good quality services. Therefore, the Commonwealth's monitoring to ensure that this provision is fulfilled is paramount. Effective, consistent and reliable monitoring requires that DBHDS develop specific data indicators and measurement criteria to inform its determination of compliance. CSBs and providers will achieve these indicators sooner, and will be more likely to sustain them over time, if they are informed of the Commonwealth's indicators and measures. The health, safety and personal growth of

the individuals served depends on the competence of the staff who support them. Ensuring that staff are indeed competent must be the common goal of both the provider's internal and the Commonwealth's external oversight and monitoring systems.

The consultant's limited review did not find compelling evidence that providers are currently able to assess and modify their staff training curricula and delivery mechanisms to ensure that all staff who provide services and their supervisors receive training that is competency-based. They cannot demonstrate the ability to meet the current requirements, and/or to expand staff competencies to effectively address the increasing complexity of the elements of services of individuals supported by their provider organizations. In addition, based on some of the descriptions of how CSBs and providers implemented the revised training requirements, it was not clear that supervisors actually assessed staff's competence.

The Commonwealth remains in non-compliance with V.H.1-2. It has drafted and subsequently revised and improved Direct Support Professional and supervisory competencies. To achieve compliance, it must inform providers of its expectations and the measurable criteria providers must meet. The Commonwealth must also develop methodologies to determine whether CSBs and providers are implementing the competency-based training, whether the trainings result in staff being able to demonstrate competence, and to revise competencies through a quality improvement process overtime to ensure that they result in the intended and desired outcomes.

IV. CONCLUSION

During the thirteenth review period, the Commonwealth through its lead agencies, DBHDS and DMAS, and their sister agencies, sustained compliance with provisions of the Agreement that it had previously accomplished. It also newly achieved compliance with an additional Quality and Risk Management provision related to investigations by the DBHDS Offices of Licensing and Human Rights. The Commonwealth also made significant progress increasing the number of individuals with IDD who are employed, who are receiving integrated day activities, and who live in smaller, more integrated residential provider homes. The Commonwealth also positioned itself to make substantial progress toward compliance with many of the provisions in the Quality and Risk Management section of the Agreement by approving emergency revised Licensing Regulations.

The Commonwealth's approved emergency revised Licensing Regulations that will allow it to make progress achieving several provisions of the Agreement that are cornerstones for the delivery of services that are consistently of good quality. The revisions to the Regulations require service providers to implement quality improvement and risk management programs, and to report reliable data from these programs to DBHDS, as it prescribes. They clarify and expand and expand the two external oversight mechanisms: during face to face meetings case managers must complete assessments whether services are being addressed appropriately, and during the Licensing process, the Office of Licensing must assess some aspects of the adequacy of services.

The Commonwealth has continued to make substantive and important progress in areas where it has not yet achieved compliance. It has substantially increased the number of individuals with IDD who are receiving integrated day activities including supported employment, and the number living in smaller, more integrated residential provider homes.

Of the provisions studied during the thirteenth period, and other than the provisions that can now be effectively addressed with the newly revised Licensing Regulations, the Commonwealth is challenged to address and resolve obstacles to needed progress in several important areas. Provider staff and their supervisors are not yet receiving competency-based training; families and agencies that provide in-home support services frequently cannot recruit and retain nurses and direct support professionals for approved hours of service; and there is a shortage of behavior specialists and when behavioral programming is available it is inadequately designed and implemented.

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

V. RECOMMENDATIONS

The Independent Reviewer's recommendations to the Commonwealth regarding services for individuals in the target population are listed below. The Independent Reviewer requests a report regarding the Commonwealth's actions to address these recommendations and the status of implementation by March 31, 2019. The Commonwealth should also consider the recommendations and suggestions in the consultants' reports, which are included in the Appendices. The Independent Reviewer will study the implementation and impact of these recommendations during the fifteenth review period (April 1, 2019 - September 30, 2019).

Behavioral Programming and Support

1. The Commonwealth should reevaluate the current status and efforts to increase the availability and accessibility of behavioral specialists and determine needed actions to address the current lack of behavioral specialists and needed behavioral supports.
2. To address the current pervasive lack of structured behavioral programming and the frequently substandard and inadequate behavioral programming that appears common. The Commonwealth should provide guidance to providers regarding the minimum expectations for what constitutes an adequately designed behavioral program and what programming elements should exist when appropriately implemented.
3. The Commonwealth should ensure that the OL determines the adequacy of existing behavioral services during the licensing process. OL should also monitor whether Case Managers are assessing whether behavioral programming is appropriately implemented.

Psychotropic Medications

4. The Commonwealth should create a Safety Alert with recommended practices to protect the health of individuals whose staff administer psychotropic medications. The Alert should include the following :

When psychotropic medications are delivered to the home a standard procedure should include the confirmation that the it is the medication, dose, frequency, time of day and route that the doctor ordered from the pharmacy.

Maintenance of documentation on-site that the individual/Authorized Representative have provided informed consent for the psychotropic medications administered.

Maintenance of readily available documentation of the possible side-effects of the psychotropic medications administered, and

Requesting that the prescriber of the medications conduct monitoring using a standardized tool for the development of tardive dyskinesia and for the digestive disorders that are often side effects of psychotropic medications.

Crisis Services

5. The Commonwealth should report to the Independent Reviewer how the CS Emergency Services programs will ensure that responses to crisis calls regarding individuals with IDD are to the individuals' homes whenever possible.

Supported Employment

6. The Commonwealth should determine the factors contributing to a slower increase than planned in individuals on the IDD waivers becoming employed. Factors to review include the role Case Managers developing goals to discuss practicable paths to employment with individuals/Authorized Representatives annually and the availability of provider capacity to develop and operate supported employment for individuals with intense needs.

Regional Support Teams

7. DBHDS should establish an aggregate goal that Case Managers will submit 95% of referrals to residences of five or more with sufficient lead time to allow the Regional Support Teams to function consistent with the requirements of the Agreement. DBHDS should consider requiring corrective action plans from the CSBs from which Case Managers fail to submit at least 85% of timely referrals quarterly to the RSTs.
8. The Commonwealth should review the root causes of the challenges of recruitment and retention of direct support staff to provide in-home support for individuals with intense behavioral needs and determine the best way(s) to address the problem.

Emergency Licensing Rules and Regulations

9. The Commonwealth should provide the Independent Reviewer with its current and planned approach to the requirement that the DBHDS Licensing process will include an assessment of the adequacy of individualized supports and services.
10. The Commonwealth's should report its measurable criteria for determining whether providers have functioning quality improvement and risk management programs.

Mortality Review

11. The Commonwealth should report quarterly to the Independent Reviewer the status of the MRC back log, the percent of MRC reviews that are held and that are completed within ninety days, and the attendance records for the member who is otherwise independent of the State.

Quality and Risk Management

12. The Commonwealth should inform providers of its expectations, including the criteria that its Licensing staff will utilize in evaluating the competency-based training for all staff and their supervisors. The evaluation should include whether CSBs and providers are implementing the competency-based training, whether the trainings result in staff being able to demonstrate competence, and whether providers have a quality improvement program in place to periodically review and revise the provider developed competencies, as needed, to ensure that they result in the intended and desired outcomes.
13. The Commonwealth should report the status of finalizing and disseminating the Community Based Risk Management Framework, the common elements of the Health Risk Assessments (completed by the MCOs), and the uniform risk triggers and thresholds, as defined by the Commonwealth, and the final version of the “Virginia DBHDS Quality Management Program”.

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APPENDIX A.

INDIVIDUAL SERVICES REVIEWS Individuals with intense behavioral needs

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**Individual Services Review Study
Individuals with Intense Behavioral Needs
Thirteenth Review Period**

Demographic Information

Sex	n	%
Male	20	69.0%
Female	9	31.0%

Age ranges	n	%
Under 21	4	13.8%
21 to 30	9	31.0%
31 to 40	8	27.6%
41 to 50	2	6.9%
51 to 60	4	13.8%
61 to 70	2	6.9%
71 and over	0	0.0%

Levels of Mobility	n	%
Ambulatory without support	25	86.2%
Ambulatory with support	1	3.4%
Total Assistance with walking	1	3.4%
Uses wheelchair	2	6.9%

Type of Residence	n	%
ICF-ID	0	0.0%
Group home	12	41.4%
Sponsored home	5	17.2%
Own home	12	41.4%

Highest Level of Communication	n	%
Spoken language, fully articulates without assistance	22	75.9%
Limited spoken language, needs some staff support	3	10.3%
Communication device	0	0.0%
Gestures	4	13.8%
Vocalizations, Facial Expressions	0	0.0%

Behavioral Needs and Supports

<i>Behavioral Needs Items</i>				
<i>Item</i>	<i>n</i>	<i>Y</i>	<i>N</i>	<i>CND</i>
Has there been police contact?	29	41.4%	58.6%	0.0%
Has there been a psychiatric hospitalization?	29	37.9%	62.1%	0.0%
Has there been the use of physical, chemical, or mechanical restraint?	29	24.1%	75.9%	0.0%
Does the individual engage in any behaviors (e.g., self-injury, aggression, property destruction, pica, elopement, etc.) that could result in injury to self or others?	29	89.7%	10.3%	0.0%
Does the individual engage in behaviors (e.g., screaming, tantrums, etc.) that disrupt the environment?	29	75.9%	24.1%	0.0%
Does the individual engage in behaviors that impede his/her ability to access a wide range of environments (e.g., public markets, restaurants, libraries, etc.)?	29	69.0%	31.0%	0.0%
Does the individual engage in behaviors that impede his/her ability to learn new skills or generalize already learned skills?	29	51.7%	48.3%	0.0%
Does the individual engage in behaviors that negatively impact his/her quality of life and greater independence?	29	93.1%	6.9%	0.0%

<i>Behavioral Programming Items</i>				
<i>Item</i>	<i>n</i>	<i>Y</i>	<i>N</i>	<i>CND</i>
If the individual engages in behaviors that negatively impact his/her quality of life and greater independence:				
Is there a functional behavior assessment in the current setting?	21	19.0%	81.0%	0.0%
Is there a written plan to address the behavior?	27	25.9%	74.1%	0.0%
If there is a written plan to address the behavior:				
Are there target behaviors for decrease?	7	85.7%	14.3%	0.0%
Are there functionally equivalent replacement behaviors/new adaptive skills targeted for increase?	7	28.6%	71.4%	0.0%
Does the plan specify the data to be collected, summarized and reviewed to determine whether planned interventions are working?	7	28.6%	71.4%	0.0%
Have the data been collected, summarized and reviewed by a qualified behavior clinician?	7	28.6%	71.4%	0.0%

Healthcare

<i>Healthcare Items - positive outcomes</i>				
<i>Item</i>	<i>n</i>	<i>Y</i>	<i>N</i>	<i>CND</i>
Did the individual have a physical examination within the last 12 months or is there a variance approved by the physician?	27	96.3%	3.7%	0.0%
Were the Primary Care Physician's (PCP's) recommendations addressed/implemented within the time frame recommended by the PCP?	19	94.7%	5.3%	0.0%
Were the medical specialist's recommendations addressed/implemented within the time frame recommended by the medical specialist?	15	86.7%	13.3%	0.0%
If ordered by a physician, was there a current psychological assessment?	2	100.0%	0.0%	0.0%
Is lab work completed as ordered by the physician?	24	87.5%	12.5%	0.0%
If applicable per the physician's orders, Does the provider monitor fluid intake?	2	100.0%	0.0%	0.0%
Does the provider monitor food intake?	5	100.0%	0.0%	0.0%
Does the provider monitor bowel movements	4	75.0%	25.0%	0.0%
Does the provider monitor weight fluctuations?	3	100.0%	0.0%	0.0%
Does the provider monitor seizures?	3	100.0%	0.0%	0.0%
If applicable, is the dining plan followed?	4	100.0%	0.0%	0.0%
Did the individual have a dental examination within the last 12 months or is there a variance approved by the dentist?	26	88.5%	11.5%	0.0%
Were the dentist's recommendations implemented within the time frame recommended by the dentist?	16	87.5%	12.5%	0.0%
Are physician ordered diagnostic consults completed as ordered within the time frame recommended by the physician?	13	100.0%	0.0%	0.0%
Is there any evidence of administering excessive or unnecessary medication(s) (including psychotropic medication)?	29	0.0%	86.2%	13.8%
If applicable, is there documentation that caregivers/clinicians Did a review of bowel movements? Made necessary changes, as appropriate?	10 6	90.0% 83.3%	10.0% 16.7%	0.0% 0.0%
If applicable, and the individual does not live in his/her own or family home, is there documentation that caregivers/clinicians: Did a review of food intake?	11	90.9%	9.1%	0.0%
Is there evidence of a nourishing and healthy diet?	29	93.1%	3.4%	3.4%
If applicable, is the dining plan followed?	4	100.0%	0.0%	0.0%

Healthcare - continued

<i>Healthcare Items - areas of concern</i>				
<i>Item</i>	<i>n</i>	<i>Y</i>	<i>N</i>	<i>CND</i>
Did the individual have a dental examination within the last 12 months or is there a variance approved by the dentist?	29	75.9%	24.1%	0.0%
Are there needed assessments that were not recommended?	29	34.5%	65.5%	0.0%
Are clinical therapy recommendations (OT, PT, S/L, psychology, nutrition) implemented or is staff actively engaged in scheduling appointments?				
Psychology	6	66.7%	33.3%	0.0%
If applicable, and the individual does not live in his/her own or family home, is there documentation that caregivers/clinicians:				
Did a review of fluid intake?	8	75.0%	25.0%	0.0%
Made necessary changes, as appropriate?	3	33.3%	66.7%	0.0%

<i>Healthcare Items -Psychotropic Medications - areas of concern</i>				
<i>Item</i>	<i>n</i>	<i>Y</i>	<i>N</i>	<i>CND</i>
If the individual receives psychotropic medication: is there documentation of the intended effects and side effects of the medication?	22	59.1%	36.4%	4.5%
Is there documentation that the individual and/or a legal guardian have given informed consent for the use of psychotropic medication(s)?	25	64.0%	32.0%	4.0%
Does the individual's nurse or psychiatrist conduct monitoring as indicated for the potential development of tardive dyskinesia, or other side effects of psychotropic medications, using a standardized tool (e.g. AIMS) at baseline and at least every 6 months thereafter)?	22	22.7%	68.2%	9.1%
Do the individual's clinical professionals conduct monitoring for digestive disorders that are often side effects of psychotropic medication(s), e.g., constipation, GERD, hydration issues, etc.?	19	63.2%	26.3%	10.5%

Individual Support Plan

<i>Individual Support Plan Items - positive outcomes</i>				
<i>Item</i>	<i>n</i>	<i>Y</i>	<i>N</i>	<i>CND</i>
Is the individual's support plan current?	29	100.0%	0.0%	0.0%
Is there evidence of person-centered planning?	29	100.0%	0.0%	0.0%
Are all essential supports listed?	26	80.8%	19.2%	0.0%
Is the individual receiving supports identified in his/her individual support plan?				
Residential	27	96.3%	3.7%	0.0%
Medical	28	92.9%	7.1%	0.0%
Recreation	26	92.3%	7.7%	0.0%
Mental Health (psychiatry)	25	92.0%	8.0%	0.0%
Transportation	29	100.0%	0.0%	0.0%
Does the individual require adaptive equipment?	20	40.0%	60.0%	0.0%
If available, is the equipment in good repair and functioning properly?	7	100.0%	0.0%	0.0%
For individuals who require adaptive equipment, is family and/or staff knowledgeable and able to assist the individual to use the equipment?	10	100.0%	0.0%	0.0%
Is family and/or staff assisting the individual to use the equipment as prescribed?	9	100.0%	0.0%	0.0%
Do the individual's desired outcomes relate to his/her talents, preferences and needs as identified in the assessments and his/her individual support plan?	29	93.1%	6.9%	0.0%

<i>Individual Support Plan Items - areas of concern</i>				
<i>Item</i>	<i>n</i>	<i>Y</i>	<i>N</i>	<i>CND</i>
Is the individual receiving supports identified in his/her Individual's Support Plan/Plan of Care?				
Dental	29	79.3%	20.7%	0.0%
Mental Health (behavioral supports)	25	40.0%	60.0%	0.0%
Communication/assistive technology, if needed	4	50.0%	50.0%	0.0%
Did the Case Manager/Support Coordinator provide education annually about less restrictive services?	17	17.6%	82.4%	0.0%
Was the individual or family given a choice of service providers, including the Case Manager/Support Coordinator?	27	3.7%	96.3%	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?	8	62.5%	37.5%	0.0%
Does the individual's support plan have specific and measurable outcomes and support activities that lead to skill development or other meaningful outcomes?	29	20.7%	79.3%	0.0%
If applicable, were employment goals and supports developed and discussed?	25	12.0%	88.0%	0.0%
Does typical day include regular integrated activities?	26	30.8%	69.2%	0.0%
Does the individual require adaptive equipment?	20	40.0%	60.0%	0.0%
If yes, is the equipment available?	15	46.7%	53.3%	0.0%

Community Residential Services

<i>Residential Staff - positive outcomes Items</i>				
<i>Item</i>	<i>n</i>	<i>Y</i>	<i>N</i>	<i>CND</i>
Is residential staff able to describe the individual's likes and dislikes?	17	100.0%	0.0%	0.0%
Is residential staff able to describe the individual's health related needs and their role in ensuring that the needs are met?	17	94.1%	5.9%	0.0%
If a Residential provider's home, is residential staff able to describe the individual's talents/contributions and what's important to and important for the individual?	17	100.0%	0.0%	0.0%
Does the individual require adaptive equipment?	29	27.6%	72.4%	0.0%
If available, is the equipment in good repair and functioning properly?	7	100.0%	0.0%	0.0%
Is the residential support staff present, knowledgeable and able to assist the individual to use the equipment?	5	100.0%	0.0%	0.0%
b. Is the residential support staff present, assisting the individual to use the equipment as prescribed?	5	100.0%	0.0%	0.0%
Do you have your own bedroom?	20	95.0%	5.0%	0.0%
Do you have privacy in your home if you want it?	20	95.0%	5.0%	0.0%

<i>Residential Staff - areas of concern</i>				
<i>Item</i>	<i>n</i>	<i>Y</i>	<i>N</i>	<i>CND</i>
Is there evidence that the residential staff has successfully completed competency-based training on the desired outcome and support activities of the individual's support plan?	11	18.2%	81.8%	0.0%
Is it documented that the support staff/sponsor home provider present successfully completed competency-based training related to the adaptive equipment prescribed?	4	25.0%	75.0%	0.0%

Integration

<i>Integration items - positive outcomes</i>				
<i>Item</i>	<i>n</i>	<i>Y</i>	<i>N</i>	<i>CND</i>
Do you live in a home in a home licensed for four or fewer individuals with disabilities and without other such homes clustered on the same setting?	12	91.7%	8.3%	0.0%

<i>Integration items - areas of concern</i>				
<i>Item</i>	<i>n</i>	<i>Y</i>	<i>N</i>	<i>CND</i>
Were employment goals and supports developed and discussed?	25	12.0%	88.0%	0.0%
If no or n/a, were integrated day opportunities offered?	24	54.2%	45.8%	0.0%
Does typical day include regular integrated activities?	26	30.8%	69.2%	0.0%
Is the individual engaged in supported employment?	27	7.4%	92.6%	0.0%
Have you met your neighbors?	15	66.7%	33.3%	0.0%
Do you go out <u>primarily</u> with your housemates as a group?	14	85.7%	14.3%	0.0%
If attending religious services is important to you/your family, do you have the opportunity to attend a church/synagogue/mosque or other religious activity of your choice?	20	65.0%	35.0%	0.0%

APPENDIX B

BEHAVIORAL SERVICES

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

To: Donald J. Fletcher

From: Patrick F. Heick, Ph.D., BCBA-D, LABA, Manager, PFH Consulting, LLC

RE: UNITED STATES v. VIRGINIA, CIVIL ACTION NO. 3:12cv59-JAG

Date: October 13, 2018

The following *Summary* and *Addendum* were prepared and submitted in response to the Independent Reviewer's request to summarize a small sample of reviews completed as part of his larger Individual Services Review (ISR) Study. More specifically, the following summary is based upon the reviews of the behavioral services for nine individuals, a sample selected from a larger sample (N=29) by the Independent Reviewer. These reviews compared the behavioral programming and supports that are currently reported to be in place with generally accepted standards and practice recommendations with regard to components of effective behavioral programming and supports – these components included: level of need; Functional Behavior Assessment (FBA); Behavioral Support Plan (BSP); care provider and/or staff training; ongoing data collection, including regular summary and analysis, and revision, as necessary. It should be noted that the Reviewer does not intend to offer these components as reflective of an exhaustive listing of essential elements of behavioral programming and supports. Furthermore, these reviews were based on the understanding that all existing documents were available onsite and/or provided in response to the Independent Reviewer's initial and/or subsequent request.

This Summary is submitted in addition to the Individual Services Review (ISR) Monitoring Questionnaires (Attachment 2) that were completed for each of the nine individuals sampled and the Data Summaries (Attachment 1). The ISR Monitoring Questionnaires were submitted separately and under seal as they contain private health information. It should be noted that the following Summary as well as data summaries within the Addenda are based upon the ISR study's Monitoring Questionnaires which were completed using information obtained during on-site visits, including observations and interviews with care providers, brief off-site phone calls with care providers and others, as well as documentation provided in response to the Independent Reviewer's document requests (Attachment 3).

Summary

Findings

1. Based on a review of the completed individuals' service records and other provided documentation as well as the completed ISR Monitoring Questionnaire, most of the individuals sampled had significant maladaptive behaviors that had dangerous and disruptive consequences to these individuals and their households, including negative impacts on the quality of these individuals' lives and their ability to become more independent. Meeting these criteria is a strong indication that most of these nine individuals would likely benefit from formal behavioral programming (or other therapeutic supports) implemented within their homes or residential programs. More specifically, of those sampled, nine (100%) engaged in behaviors that could result in injury to self or others, eight (89%) engaged in behaviors that disrupt the environment, and six (67%) engaged in behaviors that impeded his or her ability to access a wide range of environments. In addition, of those sampled, five (56%) engaged in behaviors that impeded their ability to learn new skills or generalize already learned skills. Overall, eight (89%) of the individuals sampled appeared to demonstrate significant maladaptive behaviors that negatively impacted their quality of life and greater independence. Consequently, it appeared that nearly all of these individuals would likely benefit from positive behavioral or other therapeutic supports. However, of those sampled, only four (44%) individuals were receiving behavioral programming through the implementation of Behavior Support Plans (BSPs) at the time of the on-site visit (See Figure 1).
2. As noted above, of the nine individuals sampled, four (44%) individuals had BSPs implemented at the time of the onsite visits. Of these four, three (75%) individuals had BSPs that were considered current (i.e., updated within the last 12 months); however, only two (50%) individuals had BSPs that were currently overseen by the author or other qualified behavior clinician. Lastly, none (0%) of the BSPs implemented were developed and/or implemented by a Board Certified Behavior Analyst (see Figure 2). The BCBA is the nationally accepted certification for practitioners of applied behavior analysis. This certification is granted by the Behavior Analyst Certification Board (BACB), a nonprofit corporation established to develop, promote, and implement a national and international certification program for behavior analyst practitioners.
3. As noted above, of the nine individuals sampled, four (44%) individuals had BSPs implemented at the time of the onsite visits. Of these four, only three (75%) had a Functional Behavior Assessments (FBA) completed. In addition, upon closer examination of the BSPs, it was noted

that prescribed behavioral programming appeared inadequate (see Monitoring Questionnaires for specific information). For example, although all of the BSPs identified target behaviors for decrease, none (0%) of the BSPs clearly identified and operationally defined functionally equivalent replacement behaviors. In addition, evidence that adequate data collection and review was completed for target and replacement behaviors was not found for any (0%) of the individuals sampled (see Figure 3). Overall, of the individuals sampled, zero (0%) appeared to have adequate behavioral programming in place.

4. As noted above, of the nine individuals sampled, four (44%) individuals had BSPs implemented at the time of the onsite visits. Evidence that support staff had successfully completed competency-based training on the BSP and could adequately describe the individual's behavior related needs and their role in ensuring that their needs were met was only found for one (25%) of the individuals sampled. And, although none (0%) of the BSP were found to be adequate, one (25%) of the BSPs appeared to be implemented as written (see Figure 4).

Conclusions – Areas of Concern:

1. All of the sampled individuals demonstrated unsafe behavior that placed them and others at risk. Nearly all engaged in behaviors that were disruptive and negatively impacted their quality of life. Over half of the sampled individuals demonstrated behavior that impeded their ability to access diverse community settings and that limited their ability to learn new skills.
2. Less than half of the sampled individuals were not receiving formal behavioral supports (e.g., BSPs) to address unsafe and disruptive behavior as well as skill deficits that would likely improve their independence and quality of life. And, of those who did have BSPs, half were not supervised by qualified behavior clinicians.
3. For those individuals currently identified as receiving formal behavioral supports, behavioral programming did not meet standards of generally accepted practice and were inadequate.
4. For those individuals currently identified as receiving formal behavioral supports, none received supports from BCBAs

Respectfully submitted by,

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

Attachment 1

Data Summaries:

Figure 1

Name	item 212	item 213	item 214	item 215	item 216a	item 216b
1	1	1	1	0	1	0
2	1	1	1	1	1	0
3	1	1	1	1	1	0
4	1	1	0	0	1	1
5	1	1	1	1	1	1
6	1	1	0	0	0	0
7	1	1	1	1	1	1
8	1	1	1	1	1	1
9	1	1	0	1	1	0
total (N=9)	9	9	6	6	8	4
percentage	100%	100%	67%	67%	89%	44%

Figure 2

Name	BSP	Current	Overseen by Author	Overseen by Clinician	BCBA
4	1	1	1	1	0
5	1	0	0	0	0
7	1	1	0	0	0
8	1	1	1	1	0
total (N=4)	4	3	2	2	0
percentage	100%	75%	50%	50%	0%

Figure 3

Name	item 217	item 217a	item 217b	item 217c	item 217d	item 217e	item 217f
4	1	1	1	0	0	0	0
5	1	1	1	0	0	0	0
7	1	0	1	0	0	0	na
8	1	1	1	0	0	0	na
total (N=4)	4	3	4	0	0	0	0
percentage	100%	75%	100%	0%	0%	0%	0%

Figure 4

Name	BSP	item 52	item 53	item 56
4	1	1	1	1
5	1	0	0	na
7	1	0	0	0
8	1	0	0	na
total (N=4)	4	1	1	1
percentage	100%	25%	25%	25%

Attachment 2

Individual Services Review Study; Thirteenth Review Period

August 5, 2018

By Donald Fletcher, Independent Reviewer

Requested information regarding the individuals in the selected sample

I. Contact information, as applicable:

1. Residential: Confirm that listed street address is the individual's residence. Contact person's name, email address and phone number
2. Day program: Agency name, program name (if different), address where individual attends, contact person's name and phone number.
3. Case Manager: Name, email address and phone number.
4. Service Facilitator: Agency name, Facilitator's name, email address and phone number.

II. Documents for each of the randomly selected individuals:

A. Available by August 29, 2018:

1. Service Eligibility Assessment, (e.g. SIS, Level of Functioning).
2. All Sections* of the current Individual Support Plan / Plan of Care, including assessments, ISP/POC meeting minutes (include information that was distributed at the meeting), and any amendments. Also include Case Manager/Service Coordinator progress notes and any required monthly or quarterly reports for the period from 7/1/17 through 7/31/18. (If kept separately include any monitoring assessments of risks in the new setting and monitoring/assessment tools used). *Include for all services that may occur in the individuals' homes such as service facilitation, behavior specialist, in-home nursing care, on-site crisis response or in-home services, or respite care.
3. All Investigations/Corrective Action plans for the individual's residence (7/1/17-6/30/18).
4. Behavior Programming Information: Psychological Assessment and/or Functional Behavioral Assessments; description of behavioral services provided, if a Behavioral Support Plan is in place, then provide a blank daily data sheet, behavior related staff training records; data for target and replacement behaviors (last three months); monthly data summaries and/or monthly graphed data (last three months); and any reassessments or BSP amendments since the BSP was initially approved; and consents (guardian, physician, etc.) and or review documentation (e.g. Human Rights Committee) for the Behavior Support Plan and/or for any rights restrictions, as appropriate.
5. If applicable:
 - a. For individuals who moved to a congregate facility serving five or more individuals since 7/1/16, the referral to and the response from the CRC/CIM and, if necessary, the response from the RST with identified barriers to moving to an integrated setting of four or fewer individuals. Any documentation of actions taken to address the barriers.

- b. Any reports of serious injuries; allegations of abuse or neglect; and involvement with protective services, law enforcement, crisis or emergency psychiatric services, Emergency Medical Services (i.e. 911), or unexpected hospitalizations. Include CHRIS reports related to the individual between 7/1/16 and 6/30/18.
- c. Referrals to Crisis Services; Crisis Education Prevention Plan.
- d. Investigations completed by the Residential Provider/OLS/Adult Protective Services or other similar oversight organizations.
- e. Health and Safety Support Protocols, related medical/clinical assessments; baseline data for any identified risk; documentation/data of monitoring the risk; records of data summary and review by the clinician; and any reassessments or Protocol modifications since the Protocol was initially approved.
- f. A copy of the informed consent provided for the use of psychotropic medications.

7. Additional documents requested for individuals who moved from a Training Center

- a. Discharge Plan and Discharge Plan Memo;
- b. Assessments from the TC, including the annual psychological report;
- c. Post-Move Monitoring Reports;
- d. Social Worker notes (and other documents) – that document the consultation and engagement with other families/individuals already being served in integrated community settings; and visits/tours provided to the individual/family/Authorized Representative to the options.

B. Documents requested to be available at the individual's residence, if it is not the individual's, or his/her family's, home:

- 1. Residential records including medical records and daily logs.
- 2. If applicable:
 - a. Monitoring records/data of diet, food intake, fluid intake, bowel movements, falls, or other information related to the individual's high risks.
 - b. Written protocols related to the individual's risks, including any restraint protocols.
 - c. Staff training records.
 - d. Part V Plan of Supports and related progress notes that are maintained on-site.
 - e. A copy of the informed consent provided for the use of psychotropic medications.

Attachment 3

MONITORING QUESTIONNAIRE

UNITED STATES v. VIRGINIA

SECTION 1: DEMOGRAPHICS/OBSERVATIONS

1. Individual's Name:

2. Age Range:

21-30 31-40 41-50 51-60 61-70 71-80 81-90 91+

3. Gender: Male Female

4. Mobility Status:

- Ambulatory without support
- Uses wheelchair
- Ambulatory with support
- Confined to bed

5. Residential Provider:

6. Address:

7. Telephone Number:

8. Type of Residence:

- Family/Own Home
- Sponsor Home
- Supported Apartment
- Group Home
- ICF
- Other (please specify):

9. Brief description, as observed of the individual, setting and circumstances (rather than from documents or interviews)

MONITORING QUESTIONNAIRE

UNITED STATES v. VIRGINIA

SECTION 7: SUMMARY QUESTIONS

137.	Is there any evidence of actual or potential harm, including neglect? If Yes, cite:	<input type="checkbox"/> Yes <input type="checkbox"/> No
138.	In your professional judgment, does this individual require further review? If Yes, identify the issue here and explain further on the Issues Page:	<input type="checkbox"/> Yes <input type="checkbox"/> No

SECTION 9: SUPPLEMENTAL QUESTIONS

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

217.	<p>If there is a written plan to address the behavior:</p> <p>a. Is there a functional behavior assessment in the current setting? If Yes, list the date when the assessment was completed?</p> <p>b. Are there target behaviors for decrease?</p> <p>c. Are there functionally equivalent replacement behaviors targeted for increase?</p> <p>d. Are there new adaptive skills identified to be learned?</p> <p>e. Does the plan specify the data to be collected, summarized and reviewed to determine whether planned interventions are working?</p> <p>f. Have the data been collected, summarized and reviewed by a qualified behavior clinician?</p> <p>g. Were necessary changes made, as appropriate?</p>	<p><input type="checkbox"/>Yes <input type="checkbox"/>No</p> <p><input type="checkbox"/>Yes <input type="checkbox"/>No</p> <p><input type="checkbox"/>Yes <input type="checkbox"/>No</p> <p><input type="checkbox"/>Yes <input type="checkbox"/>No</p> <p><input type="checkbox"/>Yes <input type="checkbox"/>No</p> <p><input type="checkbox"/>Yes <input type="checkbox"/>No</p> <p><input type="checkbox"/>Yes <input type="checkbox"/>No</p>
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ISSUES

(Use only for issues related to the individual reviewed that require follow-up or for issues that were resolved and commendation is warranted.)

Reviewer's Name / Title:

Date(s) of Review:

APPENDIX C

CRISIS SERVICES

In-home mobile support services

BY: Kathryn du Pree MP

2018 Review of Crisis Services Requirements of the US vs
Commonwealth of Virginia Settlement Agreement

Review Period: April 1, 2018 - September 30, 2018

Submitted to Donald Fletcher, Independent Reviewer

*By: Kathryn du Pree, MPS
Expert Reviewer
October 30, 2018*

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Section I Introduction

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

This review will include the status of the REACH programs' mobile crisis teams functioning to respond to children and adults in their homes; to provide timely assessments, services, and supports to de-escalate crises without removing individuals from their home placement. The review will also study whether REACH teams are effectively planning and identifying strategies for preventing future crises and providing short-term resources within the individuals' homes.

The study will also include the gathering information from the DBHDS standard reports regarding whether and the extent to which, during the thirteenth period, the Commonwealth continued to sustain performance with DBHDS and Settlement Agreement requirements. These data, however, will not be analyzed and reported on until the fourteenth review period. At that time the Expert Reviewer will compare the data for both reporting periods with the data from the three previous years as reported after the end of twelfth review period.

DBHDS continues to produce quarterly reports summarizing the progress of the REACH programs to meet the requirements of the Settlement Agreement as they relate to developing and sustaining a statewide crisis support system for children and adults with Intellectual Disabilities (ID) and Developmental Disabilities (DD), which will be referred to as I/DD for the remainder of this report. DBHDS is also engaging in a quarterly qualitative review of each Region's crisis services implementation for both children and adults. The report from each Region's quality review with DBHDS will be reviewed for both children and adult crisis services, and discussed in the report for the fourteenth review period.

For the thirteenth period review a qualitative review was conducted of the REACH delivery of community-based crisis services for approximately forty individuals with I/DD in Regions I, II and V who were not hospitalized, but received these community-based crisis prevention and intervention services between April 1, 2018 - July 31, 2018. The qualitative review does include some individuals who were subsequently hospitalized after July 31, 2018. This study reviews the effectiveness of the REACH programs and community behavioral, psychiatric and psychological supports to de-escalate and prevent crises; to stabilize individuals who experience a crisis; and to provide successful in-home and out-of-home supports, including community linkages for ongoing services and supports, that assist individuals to retain their community residential settings.

Section II Methodology

The qualitative study includes a review the records of forty children and adults who received REACH community-based services as noted above. DBHDS produced the list of all children and adults who received REACH services between 4/1/18 and 5/31/18 from Regions I, II and V. To create a stratified sample for this study I then randomly selected forty children and adults with I/DD who were served by REACH in the three identified Regions. This review also includes interviews with REACH staff and individuals’ case managers.

There were a total of sixty individuals who were reported as not being admitted to a psychiatric hospital during the two-month period 4/1-5/31/18 (although some were hospitalized as the eventual record review indicated). Table 1 below portrays the age groups and regional affiliation of these individuals. The sample included 68% of the individuals served by REACH in Region I; 100% of the individuals served by REACH in Region II; and 55% of the individuals served by REACH in Region V, in the time period noted. Overall the sample included 67% of all of the children and adults served by REACH in all three Regions between 4/1/18 and 5/31/18.

Table 1:
Individuals Receiving REACH Services 4/1/18-5/31/18 and Sample Selection

<i>Region</i>	<i>Adults Served thru 5/31/18</i>	<i>Children Served thru 5/31/18</i>	<i>Adults Selected</i>	<i>Children Selected</i>	<i>Total in Sample</i>
I	16	6	10	5	15
II	6	3	6	3	9
V	15	14	9	7	16
Total	37	23	25	15	40

DBHDS was asked to produce the following documentation for each of the selected individuals:

- REACH records;
- Individual Service Plan (ISP) and behavioral support plans, if applicable; and
- Names and contact information of the Case Manager and REACH coordinators

DBHDS produced all of the REACH records and all contact information. DBHDS did not share Individual Service Plans (ISP) or Behavioral Support Plans (BSP), although very few of the individuals in the sample received services from a behavioral specialist.

All four REACH teams were interviewed. Regions II and V have combined the children and adult services into one cross-trained team in each Region. Region I is the only one of five Developmental Services Department’s Regions that maintains separate children’s and adult REACH teams. We interviewed REACH team members after reviewing the records. All teams were very helpful. We appreciate the time they gave to produce all of the needed records and to answer questions. Twelve Case Managers were interviewed. We also interviewed Heather Norton, Acting Deputy Commissioner; Sharon Bonaventura, DBHDS REACH Liaison for Regions I and II and Nathan Habel, DBHDS REACH Liaison for Regions III, IV and V.

Section III Summary of Findings

This report is based on the review of the forty individuals in the selected sample, which includes twenty-five adults and fifteen children. The purpose of the record review and the interviews was to gather information to analyze the Commonwealth's efforts to provide crisis intervention and prevention services to help individuals avoid hospitalization and maintain their community settings; to determine if REACH responds to crises in a timely way, completes required plans, and coordinates effectively with families, providers and case managers; and to determine if the community system offers the necessary community supports that these individuals need in addition to REACH to continue to reside in their current residences. The analysis included a review of REACH's crisis response; whether hospitalization was avoided as a result; the provision of in-home mobile supports; the development of the crisis plan; the development of community linkages for the individual; the availability of psychiatrists and behavior specialists; the provider capacity and whether the individual retained his or her provider.

Twenty-eight of the individuals lived with their families. This included all fifteen of the children and thirteen of the twenty-five adults. The other adults lived in homes of residential service providers although in two of the cases the provider was a boarding home. Fifteen of the twenty-five adults were on one of the Home and Community Based Services (HCBS) Waivers. Most of the remaining ten adults were on a waiting list for waiver services. Only one of the children was on a waiver. Thirty-one of the individuals had a case manager, including twenty-two adults and nine children.

The individuals in this sample have a range of diagnoses. The majority (15) of the twenty-five adults have co-occurring ID and mental health (MH) diagnoses. Nine individuals have Autism Spectrum Disorder (ASD). Of these adults, four are diagnosed with ASD, ID and a MH diagnosis; two have ASD and ID; two have ASD and a MH diagnosis; and one has only ASD. One adult in the sample has only an ID diagnosis.

There are fifteen children in the sample, of who twelve have ASD. Of this subgroup, six have ASD and a MH diagnosis; one has ASD and ID; one has ASD, ID and a MH diagnosis; and four have ASD only. The remaining three children have a developmental disability (DD) and two have a co-occurring MH diagnosis.

REACH Crisis Response: Thirty-five of the forty initial calls to REACH in this review period were placed during an active crisis resulting from behaviors that involved physical aggression, property destruction and/or extreme self-injurious behavior including suicide ideation or threats. In a few cases in which police were involved they worked closely with REACH staff on the phone and on the scene. The benefit of Crisis Intervention Training (CIT) having been provided to police showed the positive results of fewer individuals being taken to the Emergency Departments (EDs). Twenty (50%) of the initial crisis calls to REACH during the review period, as well as some subsequent calls, were responded to at the person's home. Sixteen of the calls were responded to at the hospital. When able to respond to the individual's home, REACH and/or the police were able to stabilize the situations without necessitating a hospital screening. This is very significant. The Commonwealth in establishing crisis intervention and prevention services envisioned that the response to a crisis would be at the home or relevant community setting. We know from past reports that this has frequently not occurred because the CSB Emergency Services (ES) screeners do not respond to a person at their home; often REACH has not been contacted until the

individuals are in route to, or at the hospital. In all twenty situations in when REACH did respond in the home the crisis was stabilized and the individual was not removed.

The remaining calls were placed to REACH for prevention by parents or guardians. Individuals' behaviors had escalated over a period of weeks and calls were made to request in-home mobile supports. These calls indicate that these families were aware of REACH's ability to respond and to prevent admissions to psychiatric hospitals. Some of these individuals had been previously served by REACH.

REACH's response times for thirty-six of the forty calls were well within the established guidelines, as required by the Settlement Agreement. There were four calls (10%) for children that were not responded to, one in Region I and three in Region II. Fortunately, none of these children were hospitalized.

Hospitalizations Avoided: Hospitalizations were avoided for 36 (90%) of the initial calls for these forty individuals during the review period. Hospitalization did occur later for three of the adults. One was a voluntary admission for an adult who lived independently; the other two involved adults were living in-group homes. Group home staff brought the individuals to the ED prior to contacting REACH, even though REACH was providing mobile supports prior to the particular crisis. REACH was not contacted to intervene in these situations. Also, one of the other individuals was arrested later in the review period and was hospitalized from jail. REACH, Crisis Intervention Trained (CIT) officers and screeners were able to avoid hospitalization for all but four of the individuals. Another four of the forty in the sample were never in jeopardy of hospitalization. Only one child was hospitalized.

Mobile Support Offered: REACH teams offered in-home mobile supports to all of the individuals in the selected sample. This study was not focused on the use of the crisis stabilization programs, which DBHDS has labeled Crisis Therapeutic Homes (CTH) program. Two of the children in the study used a community crisis stabilization unit (CCSU) as an alternative to being hospitalized. In addition, during the review period REACH arranged CTH support for eight of the twenty-two adults who accepted REACH services. Other individuals were offered tours of the CTH, but declined the actual service.

Accepted REACH: Only one parent of a child refused the initial offer of REACH mobile supports. This parent requested CTH and REACH was able to accommodate the request. Two adults did not accept REACH services.

Utilization of Mobile Supports: REACH provided in-home mobile supports to everyone in the selected sample who was offered and accepted services. Hours ranged between a low of one and a high of eleven days. It is notable that the eleven days of mobile support to one individual are associated with a very difficult case and an excellent outcome that improved the quality of life for the child and family.

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

REACH develops goals for individuals who receive mobile supports. Not all plans include measurable objectives and progress notes toward achieving the outcomes are not routinely maintained. Service documentation can be improved. Over time, progress notes have become less therapeutic and more descriptive of the actual crisis service provided. However, it was still difficult during this review to determine what information REACH staff review, when their reviews are undertaken, what and why adjustments to plans are made, and how REACH staff are measuring success or failure related to in-home mobile supports. Because REACH plans do not include measurable objectives, it is more difficult to determine whether the individuals have made progress toward achieving the plans' outcomes.

However, the progress notes in Region II, and to some extent in the Region I adult REACH program, are more detailed describing the actual activities in depth. Overall, for the individuals selected for review (i.e. individuals who received REACH services, who were not initially admitted to psychiatric hospitals, and who did receive crisis prevention and intervention services) the REACH teams met the expectation to provide up to three days, and with the possibility of an additional period of up to three days, of in-home mobile support. Twenty-one of the individuals received more than three days of mobile in-home support.

CEPP: CEPP's were developed or updated for twenty-nine of the individuals in the sample. CEPPs could not be done for five of the individuals who had either refused REACH services (3) or discontinued services (2) before a CEPP could be completed. In one of these situations two cases, because of the existing behavioral support plan, it appropriately decided that a CEPP was not needed. In a second case, the behaviorist did not start until the child moved to an out-of-home residence. In these two cases the individuals and families are reportedly doing well per interview with REACH staff. This would indicate the positive effect of securing and involving behavioral support as early and consistently as possible with this population. Region II completed all of its CEPPs and Region I completed them for all of its children and for eight of nine (89%) of its adults. Region V, however, only completed seven of the twelve (58.3%) CEPPs that should have been done. Overall, CEPPs were completed for twenty-nine of the thirty-five (83%) individuals in the sample who chose to use REACH services.

CTH: Eight of the adults reviewed in Regions I and II utilized the CTH, all successfully. In many cases this was the option that prevented hospitalization or was planned as a step-down allowing the individual to leave the hospital sooner. There were a few instances of hospitalization that may have been avoided if a CTH bed was available. In at least two situations the local REACH team accessed a CTH bed in another REACH Region when its own CTH program was at capacity.

Linkages: One of REACH's primary focuses is to help individuals, families, Case Managers and teams establish linkages with community services that will more comprehensively help individuals to stabilize and maintain this stability; retain their residential and day providers; be assisted to find employment; and access the on-going medical and clinical supports they need to live successfully in the community. Linkages were already in place for six of the individuals in the study, and REACH did not therefore pursue linkages for these individuals. However, upon discussion with REACH or the CM it seems three of these individuals would have benefited from a behaviorist but at the time of service this option was not discussed. REACH recommended, and in many cases arranged, linkages for thirty of the thirty-four individuals who needed community linkages. These included connections with CSBs and CMs; pursuing waiver eligibility; DARS for employment support; day programs; outpatient therapy; family counseling; mental health support; neurologists; psychiatrists; independent skill training; and accessing services for a family moving out of state. The Region I REACH Adult program arranged linkages for all of its participants and Region II arranged linkages for all of its children and adults. Overall linkages were arranged for 88% of individuals selected for this study.

Psychiatry: Thirty-four of the selected individuals have a psychiatrist; psychiatric support is unknown for one person; and five individuals do not have a psychiatrist. Two cases are unusually concerning. One psychiatrist refused to continue treatment. For another the CSB would not provide the child with a psychiatrist because the parents had Tri-Care (military) health insurance. All five of the individuals without a psychiatrist are children, four of whom live in Region V.

Behaviorist: This continues to be the least available and most needed support to assist individual and families who have co-occurring conditions and present behavioral challenges. Only six individuals had a behaviorist. A behaviorist is not needed for another eight individuals. One individual had a behaviorist scheduled to conduct the initial evaluation but the family has cancelled the appointment. Twenty-five of the forty individuals in the sample cannot access a behaviorist but need this expertise. This is a significant area of need in Virginia for individuals with I/DD.

Case Manager: Thirty-two of the individuals were reported as having a case manager. Two CMs we called indicated they were not the CM for the individual but an intake worker. We were unable to get the name of the actual CM for these two individuals. We were able to interview seventeen of the CMs: one had two of the individuals in the study. Fourteen of the case managers did not respond to a request to be interviewed. The CMs who were interviewed were very positive about REACH services, with one CM being more neutral, but acknowledging REACH had maintained contact during the delivery of crisis services. CMs report REACH is very supportive of the individuals and families experiencing crises; communicates and coordinates effectively with the CMs; involves CMs in the development of CEPPs; provides quality mobile support; and prevents hospitalizations. The only complaint was that REACH did not always share the CEPP. REACH indicated the CEPP is part of the electronic record and available to the CM if they work in the same CSB as the REACH team. REACH staff may want to share these plans as part of the protocol so CMs can then reinforce the plan with families and providers.

There were two concerns expressed about REACH, one by two different CMs. One concern is that REACH staff cannot intervene directly when an individual is being aggressive or assaultive. The one CM who expressed this concern felt if REACH staff could intervene, especially with someone who escalates in a family home, more hospitalization screenings could be avoided. The other concern is that REACH sometimes does not respond on-site to a call but just over the telephone.

The instances of this occurring were with two individuals. It was for subsequent calls, not the initial crisis call in the reporting period. The CMs think this is the result of inadequate staff available to always be able to respond in person.

This is much more positive feedback than CMs offered during the early stages of REACH's evolution. It speaks to the staff competency, maturity, and quality of the program.

Provider Capacity: *Table 2* summarizes the number of individuals who maintained their provider at the time of the crisis. Twenty-eight maintained either their family home setting or residential provider; nine lost their residential setting, including one person whose family made him leave upon high school graduation; and three individuals transitioned to new residential providers that their families were seeking prior to the crisis. Six of the group home providers discharged the individual as they were not properly staffed or trained to address the needs of the individual. In two cases individuals were hospitalized because the providers refused to have them return to their group home. One provider was seeking a protective order against the individual.

One additional individual was arrested and jailed due to starting a fire outside using an accelerant. He decompensated in jail and remains in the psychiatric hospital to which he was transferred. This provider is apparently willing to serve him again, but the original setting they chose for him and the inconsistency of staffing led to his crisis and arrest.

Not all providers were willing to accept training from REACH, to follow the CEPP or to implement recommendations for linkages or improvements in the structure and expectations of the day programs. Some of the individuals had crises during the summer when they did not have structured or meaningful daytime activities. The competency of provider staff and the capacity to effectively support individuals with significant behaviors remains a challenge for the Commonwealth. This lack of behavioral provider capacity makes it very difficult to successfully maintain individuals with I/DD and either behavioral or mental health challenges in their residential settings and their communities.

REACH Program Impressions: Overall, for the individuals reviewed for this study, REACH is accomplishing the intended goals of stabilization via mobile supports and use of the CTH program. REACH responds to crises in a timely way and provides extensive mobile in-home supports generally. REACH works effectively with Case Managers and takes the responsibility to arrange community linkages seriously. The extensive cross systems work necessary in a few of these cases was exceptionally well done and had very positive results. The success could be more consistent with less recidivism if a behaviorist were put in place for all who displayed that need. It is understood that the lack of resources in the profession is a national issue. Virginia needs to evaluate its efforts to increase the number of behaviorists and determine if its efforts need to be enhanced.

Interviews with the REACH teams again showed that Region I continues to show improvement and to solicit feedback to improve its services. Region V continues to struggle with the development and implementation of CEPPs and to consistently facilitate the creation of needed linkages. Region II continues to be a steady performer with the development, updating and implementation of CEPPs and the creation of community linkages.

Table 2 Summary
REACH and Community Services for Individuals Reviewed

in the 13th Review Period

INDIV.	A/C	REACH CRISIS RESPONSE	HOSPITAL AVOIDED	OFFERED MOBILE SUPPORT	ACCEPTED REACH	MS AMOUNT USED	CEPP	CTH	LINKAGES	PSYCHIATRY	BEHAVIORIST	CM	PROVIDER (F/P)	MAINTAINED PROVIDER
RI-1	A	Y	Y	Y	Y	6	Y	Y	Y	Y	N	Y	F	Y
RI-2	A	Y	N	Y	Y	3	Y	Y	Y	Y	N	Y	P	N
RI-3	A	Y	N/A	Y	Y	5	N/A	Y	N/A	Y	N/A	Y	F	Y
RI-4	A	Y	Y	Y	Y	4	Y (1)	N	Y	Y	N	Y	F	Y
RI-5	A	Y	Y(5)	Y	Y	4	Y	Y	Y	Y	N	Y	P	N
RI-6	A	Y	Y	Y	Y	5	Y	N	Y	Y	N/A	Y	P	N
RI-7	A	Y	Y	Y	Y	9	N	N	Y	Y	N/A	Y	P	Y
RI-8	A	Y	N	Y	Y	4	Y	Y	Y	Y	Y	Y	P	N
RI-9	A	Y	Y	Y	Y	3	N	Y	Y	Y	N	Y	P	N
RI-10	A	Y	N/A	Y	Y	4	Y	Y	Y	Y	N/A	Y	F	N/A (2)
RI-11	C	Y	Y	Y	N	N/A	Y	Y(3)	Y	Y	N	Y	F	Y
RI-12	C	Y	N	Y	Y	3	Y	N/A	Y	Y	N	Y	F	Y
RI-13	C	N	Y	Y	Y	3	Y	N/A	N	N	N	N	F	Y
RI-14	C	Y	Y	Y	Y	7	Y	Y(3)	N/A	Y	N/A	Y	F	Y
RI-15	C	Y	Y	Y	Y	9	Y	N/A	Y	Y	N	Y	F	Y
R2-1	A	Y	N/A	Y	Y	4	Y	N	Y	Y	N(7)	Y	F	Y
R2-2	A	Y	Y	Y	Y	9	Y	N	Y	Y	Y	Y	P	Y
R2-3	A	Y	N/A	Y	Y	4	Y	N	Y	Y	N	Y	F	Y
R2-4	A	Y	N	Y	Y	10	Y	Y	Y	Y	N/A	Y	F	N/A (2)
R2-5	A	Y	Y	Y	Y	3	Y	N	Y	Y	N	Y	F	Y
R2-6	A	Y	Y	Y	Y	3	Y	N	Y	Y	N	Y	F	Y
R2-7	C	N	Y	Y	Y	5	Y	N/A	Y	Y	Y	N	F	Y
R2-8	C	N	Y	Y	Y	4	Y	N/A	Y	Y	N/A	Y	F	Y
R2-9	C	N	Y	Y	Y	8	Y	N/A	Y	Y	Y	N	F	Y

INDIV.	A/C	REACH CRISIS RESPONSE	HOSPITAL AVOIDED	OFFERED MOBILE SUPPORT	ACCEPTED REACH	MS AMOUNT USED	CEPP	CTH	LINKAGES	PSYCHIATRY	BEHAVIORIST	CM	PROVIDER (F/P)	MAINTAINED PROVIDER
RV-1	A	Y	Y(4)	Y	Y	3	Y	N	Y	Y	N	Y	F	N
RV-2	A	Y	Y	Y	Y	4	N/A	N	N/A	Y	N	N	P(6)	Y
RV-3	A	Y	Y	Y	N	N/A	N/A	N/A	N/A	UNK	N	N	F	Y
RV-4	A	Y	Y(5)	Y	Y	1	N/A	N/A	N/A	Y	N/A	N	F	Y
RV-5	A	Y	Y	Y	Y	7	Y	N	Y	Y	Y	Y	P	N
RV-6	A	Y	Y	Y	Y	3	Y	N	Y	Y	N	Y	P	N
RV-7	A	Y	Y	Y	N	N/A	N/A	N/A	N/A	Y	N	Y	P	N
RV-8	A	Y	Y	Y	Y	11	Y	N	Y	Y	N	Y	P	Y
RV-9	A	Y	Y	Y	Y	3	N	N	Y	Y	N	Y	F	Y
RV-10	C	Y	Y	Y	Y	5	N	N/A	Y	Y	N	N	F	Y
RV-11	C	Y	Y	Y	Y	1	N	N/A	N	N	N	Y	F	Y
RV-12	C	Y	Y	Y	Y	1	Y	N/A	N	N	N	Y	F	Y
RV-13	C	Y	Y	Y	Y	3	N	N/A	Y	Y	Y	Y	F	N/A (2)
RV-14	C	Y	Y	Y	Y	5	N	N/A	Y	Y	N	Y	F	Y
RV-15	C	Y	Y	Y	Y	1	Y	N/A	N	N	N	N	F	Y
RV-16	C	Y	Y	Y	Y	3	Y	N/A	Y	N	N	Y	F	Y
Total Met		89%	89%	100%	92%		80%	42%	88%	87%	19%	80%		76%

- (1) Interim CEPP completed. Family stopped services before full CEPP could be done
- (2) The individual or family had been pursuing a new placement and it was successfully found
- (3) These children used a stabilization unit
- (4) The initial hospitalization was avoided in June. He was subsequently kept in a hospital one night in August because he was homeless
- (5) The initial hospitalization was avoided in both cases. However, there were some subsequent hospitalizations in the reporting period. One individual, RV-4 had many voluntary hospitalizations when REACH was not notified
- (6) This provider is a boarding home
- (7) The CM has located a behavioral specialist who made an appointment with the individual which the family cancelled

Attachment 1:

Summaries of Individuals in the Qualitative Study for the 13th Review Period

This attachment offers a summary of each individual in the sample and the REACH and community services that were found to be in place for them. An adult section and a children's section divide it. Each individual has a number to identify him or her, which is used on Table 2 and in this attachment. The Roman numeral denotes the Region that serves them.

Section A Adults

I-1 This individual is diagnosed with Autism Spectrum Disorder (ASD), Bipolar Disorder, and Moderate Intellectual Disability (ID). Documentation shows that this individual has had a long history with REACH services dating back to at least 2014. He has had previous psychiatric hospitalizations and multiple involvements with police at his home that resulted in Emergency Commitment Orders (ECOs). For this reporting period he had two ECOs from 4/1/18 to 6/4/18. REACH was able to avoid hospitalization for both incidents by providing an alternative stay at CTH. In addition, during April and June, between stays at the CTH, REACH was able to deescalate an incident via phone and coordinate with REACH in-home worker to avoid an incident in the community that would have surely warranted police involvement and most probably another ECO.

The most recent CTH stay on record was for 30 days in June. Excellent progress was made during this time period as evidenced by progress notes indicating a dramatic reduction in unregulated behavior accompanied by aggressive and assaultive episodes. As of the last progress note, there had been six consecutive days without negative behaviors being displayed. In addition, notes showed that he had begun to process verbally the coping strategies that he was being taught. REACH was also in regular contact with the Case Manager who was working on finding a group home for this individual given the inability of family to continue to have him live with them. Linkages in place at time of initial contact were school, PCP, psychiatrist and Case management. CEPP was an updated version of one developed in 2017.

REACH reported that individual left CTH placement abruptly on 6/19/18 due to his mother becoming panicked over a need to reschedule an appointment with his community psychiatrist. REACH needed to reschedule as neither the mother nor case manager knew that REACH was not transporting him to the appointment per REACH protocols.

Linkages facilitated by REACH were for a neurologist and group home visits. Communication with the CM was reported as consistent and frequent. The CM was not very knowledgeable of Autism Spectrum Disorders so staff spent time educating her. REACH reported that the CM was receptive and initiated communication in addition to REACH initiated communications.

Case Manager Interview. The CM reported that individual is doing quite well and preparing to move into a group home. This will be his first out-of-home placement. The group home is approximately 40 minutes from his parents' home. He has had three visits to date, one day and two overnights. The CM is meeting with the family later in the week to get their feedback. There is a day program associate with the GH, which the individual will also attend. Employment is planned at some point in the future. After graduation from school, previous attempts failed due to

behavioral issues. The CM is planning to request behavioral consultation once the individual becomes settled in the group home.

The CM also reported that REACH involvement has been the stabilizing component and has given him skills that allow him and his family an improved quality of life. The CM reported that when individual was at the CTH, REACH contacted her one to two times per week and shared all plans with her. She feels REACH does tremendous work and is very communicative and knowledgeable.

I-2 This individual is diagnosed with moderate ID and an Adjustment Disorder with mixed disturbance of emotional conduct. This individual has been associated with REACH for quite some time. He has a history of multiple psychiatric admissions including some that were voluntary. He is very independent and appears to utilize REACH crisis line services frequently, appropriately and with much success. He moved to a group home on April 21, 2018 from his lifelong home shortly after his mother's death. He had a voluntary admission to a psychiatric hospital in early May. He was discharged to the CTH within five days for a short stay. REACH staff involved group home supervisor and staff in planning and training for his return. Supervisor admitted at beginning of training that he and staff had little to no experience with mental health issues and were unsure how to support this individual. Individual subsequently lost this group home placement in May. Provider had him transported to ED under ECO and was eventually hospitalized via TDO. He was discharged again to CTH. REACH worked closely with case manager to locate an appropriate group home given his high level of functioning and his mental health needs. CEPP was an updated version of one previously developed in 2017.

REACH reported that individual is now on monitoring status. He has been stable since moving to new group home on 7/1/18. He has had an active case manager the entire time of REACH involvement. Had a bed been available in May the hospitalization would have been avoided.

Case Manager Interview. The CM did not respond to request the for an interview

I-3 This individual's diagnoses include ASD, ID, Attention Deficit Disorder, Mood Disorder and Bipolar Disorder. His initial REACH contact was in 2014. At that time, he received in-home services. He had a crisis stabilization plan in 2016 and received in-home supports to implement the plan. He received REACH services during this review period from 6/19/18-6/23/18. His family requested in-home mobile support to help him address a period of time that is stressful for him each year. His goal was similar to his goal in 2017 as a result of a time specific event that impacts his anxiety. Treatment plan goals and an ISP were developed and the team used a provisional crisis plan. In-home supports were provided daily for up to six hours a day for the time period expected. The services were successful in reducing his anxiety, helping him to develop coping mechanisms and remain home with his family. The CEPP was completed but there is no evidence of coordination with the Case Manager or team. However, the request to REACH was very specific related to an acute crisis situation that occurs annually and is resolved rather quickly. He did not need help with community linkages. He has an outpatient therapist and speech therapy. His parent is a Mental Health Practitioner and coordinates the community supports he needs.

Case Manager Interview: His CM reports that he is stable at home but is becoming anxious because his father is scheduled for surgery soon. She plans to reengage REACH. She does believe he needs a behavioral specialist because his issues are primarily related to his anxiety. He continues to see his outpatient counselor twice a month. REACH was very helpful and he responded well to the REACH workers. His family was satisfied with both the in-home mobile supports and the CTH.

I-4 This individual's initial contact with REACH was in 2016 as a result of physical aggression in the community, police involvement and intake by the ED of a private hospital. He has a diagnosis of Anxiety Disorder, unspecified ID and ADHD. He started receiving REACH services on 5/7/18 during this review period, and an emergency referral was made on 5/29/18. His living arrangement with his family was in jeopardy. He had been discharged from his day program due to instability. He had numerous stressors in his life and significant changes in his family situation due to health issues. Overall, he received REACH support between 5/7/18 and 6/1/18. REACH staff responded in person on 5/7/18 to provide crisis prevention and intervention planning and crisis stabilization, assisting at his day program. The crisis interim plan was to help him develop coping skills and to train the staff in behavior management techniques. However, his day program discharged him prior to this being scheduled.

He was seen in the ED on 5/25/18 and stayed overnight. He was seen at the ED after striking a nurse while there for a medical reason. REACH responded onsite and was able to help de-escalate the situation. He remained overnight and was discharged home with mobile support REACH met his mother at the ED. He returned home the next day. REACH provided in-home supports from 5/29/18-6/1/18, between four and six hours per day. A crisis stabilization plan was developed on 5/29/18 and was implemented by REACH staff. Recommendations were made to connect him to the CSB for case management services and for him to be placed on the waiting list for waiver services; see his psychiatrist; meet with his team; and provide in-home crisis support. REACH planned to assist to develop a structured day for him. REACH worked with him and trained his parents on strategies to help him establish appropriate boundaries. REACH did work with him and trained his mother. His father was reported to APS because of threatening behavior. REACH followed up with his family in July and August when his mother indicated he was ready to be discharged from REACH. REACH linked him with case management and assisted the family to apply for the waiting list. They assisted the family to have him reconnect with his psychiatrist. His medications had been adjusted and he was on the Waiver Waiting List.

Case Manager Interview: His CM did not keep her scheduled phone interview or re-schedule.

I-5 This individual is diagnosed with Schizoaffective Disorder, Post-Traumatic Stress Disorder (PTSD), Obsessive Compulsive Disorder (OCD), and mild ID. The individual was involved with REACH since 2017. Involvement with this individual during this reporting period occurred almost daily with multiple CTH stays after psychiatric hospitalizations, mobile supports and crisis coordination that avoided additional hospitalizations. Cross systems work has been constant with REACH facilitating connections for trauma therapy, OT, PT and gynecology. The CEPP used by the team was an updated version of one developed in 2017.

REACH reports that this case is still open and very active. When asked about documentation revealing a strong potential for poly pharmacy, the team responded that that had been addressed and medication regime had been reviewed by psychiatrist and adjusted to resolve issue of poly pharmacy.

Case Manager Interview. The CM reports that individual just returned from a three-month stay at Western State Hospital. She did not return to the group home but moved into a sponsored home where she is the only client. She has returned to her day program and all linkages are in place. The CM is working on reengaging OT and PT and is following up on routine physician visits. REACH maintained phone contact with the CM during the recent hospitalization. Prior to hospitalization REACH was very involved, developed coping strategies and worked with group home staff and the individual on the implementation of the strategies. In reference to crisis stabilization, the CM praised the REACH call line worker and the onsite worker for effective communication and teamwork. The CM stated that for a few years she did not think highly of REACH but that is not the case presently especially with this individual. "They have been excellent and they just continue to improve".

I-6 This individual was previously served by REACH in 2016. At that time, he was supported in the CTH for fifteen days. His diagnoses are ID and Schizoaffective Disorder. He lives in a sponsored residence, living alone with 24-hour support. He is on the I/DD comprehensive waiver.

During this review period he received REACH services from 4/27/18-8/14/18. He was initially referred on 4/27/18 because his staff reported he was having a psychotic break and exhibiting sexualized behavior with staff. REACH had interactions with him, his staff and his mother between 4/27/18 and 5/16/18 that included five days of in-home support of four hours each day. REACH staff counseled him on identifying stressors, developing coping strategies, and identified techniques the staff could use to assist him to develop appropriate social skills. REACH recommended that he see a psychiatrist for depression, have his medications reviewed, see a therapist for PTSD, and be assisted to work, in which he expressed interest. REACH followed up with his case manager at his mother's request to hear her concerns with the quality of his provider. The CEPP was developed on 5/7/18.

He was referred to REACH again in June. His mother called because he was in jail as a result of setting his clothes on fire outside. The charges were for felony arson because he used an accelerant. REACH contacted the Disability Law Center to try to assist him with legal representation. He was jailed but decompensated over a few weeks. He was then placed at Western State Hospital (WSH), first to address the decomposition then for a competency evaluation. REACH remained involved with him while he was in jail and visited him at WSH when he was first transferred. This is a tragic situation. The provider had him living in a trailer with individual supervision. He did not want to live in a trailer. He reported this brought back memories of the time he was married and lived in a trailer, which he also set on fire but was never arrested. At his present home he had Tike torches to light his cigarettes. One day he told the staff to leave as he was going to set a fire outside. The staff left and called the police. The outside fire affected neither him nor the trailer. REACH is prepared to support him if he returns to the community but it seems more likely he will be committed to WSH.

Case Manager Interview. She reports that to her knowledge he did not have a history of fire setting but one of property destruction. She has had ongoing contact with the provider and REACH staff.

The provider is ready to support him again but the team agrees he needs a more structured living situation with knowledgeable staff to provide continuous supervision. She was impressed with the rapport REACH staff was able to establish with him. She said it was unique that he would connect so quickly with new staff. She found their intervention with him to be very helpful. She was more concerned with the consistency and skills of his residential staff.

I-7 This individual, who is diagnosed with ASD, has been involved with REACH for quite some time and has a significant history of hospitalizations with two in a two-week period during May 2018. A third hospitalization in May was avoided due to the implementation of a thorough Crisis Stabilization Plan during mobile supports provided over a four-day period. It appears that a new day program and his mother hindering his independent living situation triggered extreme anxiety episodes. The Case Manager in mid-May suggested moving him to a different waiver with a group home as his living option if necessary. REACH staff was able to facilitate a behaviorist provider and provide regular support to avoid removal from independent living. No CEPP was provided.

REACH reported the individual is presently doing very well and avoiding hospitalization. He has been utilizing REACH on a regular basis calling the crisis line and talking to a REACH worker. In addition, he is responding well to the behavioral program and remains living independently and attending day program regularly. CEPP was developed previously but not used during this reporting period because of the positive behavioral plan.

Case Manager Interview. The CM reports that individual is doing very well due to all the work REACH has done and continues to be involved with the individual. The CM states he is a very high needs individual due to the mental health, DD and general health issues. These include, but are not limited to, a heart valve replacement surgery, diabetes and being overweight. The individual has lived independently for twelve years and guards his independence strongly. He has in-home support services two days per week for three hours each day and he decided which days. He recently made the decision to stop attending a day program. The group providing Positive Behavioral Supports offered to increase their time from two days to three days per week, to which he agreed. His CM believed his most important need at this point is medical monitoring on at least a weekly basis if not daily given his diabetes. The individual is opposed to such monitoring but sees his PCP for regular level checks and guidance. REACH staff attends all his medical appointments with him per his request. REACH remains very involved as they attend all his team meetings and meetings with PBS Provider. REACH always calls the case manager first on any crisis to inform her of the event and status and they are always at the hospital before any case manager and provide wonderful support in that environment. They are very helpful and without them this individual would be hospitalized on a majority of ED visits.

I-8 This individual is diagnosed with Anxiety Disorder, Bipolar Disorder, Dementia, and moderate ID. He has been involved with REACH for a number of years with a high number of CTH stays. During the 13th reporting period he has had contact at least monthly and usually weekly, documented through progress notes. He has experienced a number of hospitalizations with two during this reporting period. It is important to note that both hospitalizations were initiated by group homes that refused to allow him to return. REACH staff was involved in the hospitalization in April. The individual had nowhere to live and the CTH had no available beds. REACH developed a CTH placement within two days in another region. The second hospitalization was similar in that REACH, the attending physician and judge developed a plan for an overnight stay in

ED and next day move to CTH with a seven-day stay. Both the CEPP and Crisis Stabilization were completed.

REACH reported that the individual lives at a group home in Region IV. Cross systems work led to this move. During his stay at the CTH in Region I, a transfer to Region IV CTH was coordinated due to bed availability issues. A GH in Region I was found but they could not support him. REACH organized a return to the CTH and REACH in Region IV found a more suitable group home. The crisis stabilization plan was developed and shared with group home who chose not to be trained. Brother and Case Manager then were well trained on the plan by REACH. REACH stays in regular contact with the case manager and brother who monitor use of plans developed by REACH.

Case Manager Interview: The CM reported that the individual currently resides in a GH in Region IV that is close to his day program. Since his move on July 1st there have been no episodes or issues to date. Case manager has a visit planned for 10/29 and will let REACH know how he is doing. All linkages are in place and recent dental visit resulted in two planned extractions. REACH's communication and assistance has been excellent with them coordinating many things and always keeping the CM informed. The Case Manager was impressed with how much REACH involved her on the CEPP development.

I-9 This individual is diagnosed with Depressive Disorder, generalized Anxiety Disorder, and mild ID. He has been involved with REACH for a number of years. Interaction during this reporting period began on 4/2/18 with group home staff bringing the individual to ED. REACH intervened at the ED avoiding hospitalization and supporting him to return to the group home. On 4/20/18 group home staff contacted police and had individual transported to ED again where REACH intervened again and was able to provide a CTH stay. The attending physician recommended a medication review while at CTH. Her stay at the CTH was extended to 6/21/18 in order to find an appropriate group home. She moved to a GH in RIII in July. Review of notes shows a poly pharmacy issue. REACH developed a crisis stabilization plan. There was no documentation of a CEPP.

REACH reported the individual did very well while at the CTH. She stabilized and learned to use coping strategies taught by REACH staff and learned to communicate and identify triggers very well. Poly pharmacy was addressed and corrected by the REACH psychiatrist and replaced with appropriate medication regime. Team said they did develop a CEPP but it was not forwarded for review.

Case Manager Interview: The Case Manager did not respond to the request for an interview

I-10 This individual's original intake with REACH was in 2017. His diagnosis is mild ID, Cerebral Palsy, and Adjustment Disorder. He lives at home with his family, has a Case Manager and receives outpatient treatment from a mental health provider. In 2017 he went to the CTH for crisis stabilization and subsequently received fifteen days of in-home support. A CEPP was developed in 2017.

He was referred again on 5/1/18 for in-home mobile crisis support because he was showing signs of depression and was withdrawing from interactions with his family. His mother, with whom he had lived all of his life, died and he moved into his sister's home. The same goals were in the ISPs of 2017 and 2018. In-home mobile supports were provided from 5/1/18-5/4/18. He received between one and four hours of in-home support each day. The counselor worked with him to develop coping strategies and identify preferred activities and with his family to help them understand the impact of his mother's death. He wants to move to a GH and is on the Waiver Waiting List. REACH recommended follow up with his psychiatrist and PCP; a planned stay at the CTH; ongoing in-home support until he could transition to a group home; and referred him for grief counseling. He has a day program and was approved for forty hours of intensive in-home support from a waiver provider. He does not need a behaviorist.

REACH reported he is now stable and is on a monitoring plan, which entails regular phone contact. Prior to this REACH was able to train his day and in-home staff. He realized his goal of moving to a group home in late September.

Case Manager Interview: He is very happy and stable in the group home. The CM had requested a GH under the waiver but the sister had been reluctant until recently. He had medical issues with his shunt during the review period. These were addressed which had a positive impact on him and his mental health. The CM reported REACH was extremely helpful to him and his sister. He benefitted from both mobile supports and a planned stay at the CTH. REACH trained both his day and in-home support staff. REACH offered to train the GH staff but these staff did not need crisis stabilization training.

Region II

II-1 This individual, who is 58 and diagnosed with severe ID and OCD, lives at home with her family. She was first referred in 12/15/17 for prevention mostly to help the family plan for transition from the family home, where she has always lived. During this review period she received REACH services from 4/5/18-5/9/18. There was additional follow up with the family through 8/15/18. A provisional CEPP was completed on 4/10/18 and a comprehensive CEPP on 5/23/18. She has a "care worker", a case manager and a psychiatrist. In-home mobile crisis support was provided for four days with 1-2-hour sessions to address her anxiety triggers and teach her coping skills. Additionally, her family was trained in the CEPP; visits were offered to the CTH that were refused by her parents; and an offer was made to assist them with community linkages as they sought a suitable residential provider. REACH offered to extend the in-home mobile supports on 5/24/18 and again on 6/6/18 but the family did not feel there was a continued need.

REACH reported she remains at home and stable. She has been on monitoring status with REACH for the past three months including phone follow up and face-to-face visits with her family. The family did visit the CTH with her so it is an option in the future. She is now on the waiver and

will be starting a day program. REACH recommended a behaviorist but she is not working with one yet. REACH's psychiatrist consulted with her community psychiatrist.

Case Manager Interview: The CM reports she is stable now. She is participating in a day program offering community engagement and community coaching longer. She is no longer bored, which is contributing to her improved mood and stability. The family appreciated the initial response by REACH and the in-home mobile supports from 4/25/18-5/9/18 and the offer to tour the CTH. They were not ready to use the CTH. They discontinued REACH services because after the first face-to-face response to her crisis the REACH staff always attempted to address her crisis by phone, rather than meeting her at her house. None of these calls to the REACH crisis line led to a hospital screening but the family wanted REACH to come to her home in response to each call to the REACH hotline.

II-2 This individual is 25 years old and is diagnosed with ASD, Pervasive Developmental Disorder (PDD), severe ID, and Anxiety. She was first referred to REACH on 3/30/18. She was referred for an increase in physical aggression during the transportation to and from her day program, which sometimes requires police intervention. She was also urinating in public areas of the day program. One time a CIT officer was called to assist the staff. A residential provider serves her. She has a CM and a Behavioral Specialist. She continued to have more stable behavior at home than she exhibited at her day program.

She received in-home mobile supports from 5/10/18 - 5/24/18, mostly at the day program. Prior to that the REACH team met with her team, developed a provisional CEPP, and provided phone consultation. The comprehensive CEPP was developed on 5/23/18. The in-home mobile supports included positive behavioral support and behavioral monitoring. These were to address being able to identify her triggers, develop coping skills, learn to communicate in a safe manner and be engaged in preferred activities. REACH recommended that she be seen by her PCP to rule out a medical cause for her increased intake of both food and water, and connected her team to a behaviorist. REACH also recommended the team explore an alternative day program. REACH held a discharge meeting and completed supports on 6/22/18. The team was satisfied with the support from REACH.

REACH reports she is stable at both her residence and day program. The crisis plan helped staff address the food and transportation issues more consistently. REACH helped the staff at the day program to understand that they needed to give her more control over her own life, while accessing her strengths and interests. She is now inactive with REACH.

Case Manager Interview: The CM reported she is doing well at both her residence and her day program. She has a behavioral specialist who has developed a BSP for the day program to follow. The BSP addresses her food seeking and other aggressive behaviors. The CM reports REACH was helpful and maintained good communication with the CM and her ISP team while REACH provided mobile supports at the day program. She speaks positively of REACH's involvement but indicates they cannot always respond onsite to follow up calls because of a lack of staffing to meet the needs within the Region. She also voiced that it is frustrating that REACH staff cannot intervene directly with someone who is aggressive or assaultive. She believes if the REACH staff could do that more hospitalizations could be avoided.

II-3 This individual is nineteen and lives at home with his family. His diagnosis is PDD, Attention Deficit and Hyperactivity Disorder (ADHD). His initial referral was on 4/12/18. He was referred because of physical and verbal aggression, property destruction, preservation, change in sleep pattern, and mental health symptoms. His brother has a chronic illness and was experiencing a setback. His father travels extensively for work. His heightened anxiety was impairing his executive functioning. He has a new aide at school who is stricter. He was not at risk of hospitalization or of losing his home.

He received REACH services between 4/26/18 and 5/24/18. REACH completed a crisis assessment, a crisis stabilization plan, a provisional CEPP and a comprehensive CEPP. REACH worked with him to develop emotional awareness skills; alternative means to communicate his emotions and needs; and with the family to learn alternative strategies to help him communicate effectively. In-home mobile supports were planned for mid to late May after all the assessments and observations were done but his mother cancelled them at first because his brother was hospitalized. They were re-scheduled and provided for three days for two hours each day. Activities were offered to him and included his family to address coping skill development and communication. The family was taught to build some of the techniques into his evening routine at home. His mother received further training in the CEPP in late June. She requested one session in late July to help him with anxiety around his birthday. The session was conducted. REACH developed a contingency summer schedule for him because he was not in school and was refusing to attend his usual camp. He himself called the hotline in August. Hotline staff was able to respond and assist him to calm.

REACH reports he is active with the program. His parents are reactive. Because he is very verbal the family over estimates his functional abilities and places unrealistic expectations on him. REACH has recommended a BCBA to help them more long-term. The family is interested in a residential placement for him and he is now on the Waiver Waiting List. REACH has also suggested a referral to DARS as he expresses an interest in working. REACH offered a tour of the CTH but the family has so far declined the invitation. REACH continues to monitor him and contacts him two to three times a month. REACH has encouraged him to use the mobile crisis line directly, which he does.

Case Manager Interview: The name given for his case manager was not his, and a second name listed was an intake CM who did not know him. However, the first CM called had an individual on her caseload who used REACH this review period. She found their assistance to be exemplary helping her stabilize and then find residential support for an individual who was homeless at the time.

II-4 This individual is 41 years old and diagnosed with ASD and Bipolar Disorder. He is seen by a psychiatrist and has a CM. He resides in a GH and has been referred to DARS for a vocational assessment. He was originally referred to REACH on 9/14/17. He was hospitalized at that time for property destruction and verbal aggression. REACH provided CTH support as a step-down from the hospital. His stay was extended when he requested a new residential program. He had been in a residential sponsored home and requested to live in a group home. Eventually after another hospitalization and another CTH stay for step-down, he is awaiting his new residential placement.

During this reporting period the REACH team trained the new provider on the elements of his comprehensive CEPP. He was living at his family home waiting for the new residential sponsor to

be ready to support him in late May. However, the new provider declined to support him in early May. REACH provided four days of in-home mobile support at his mother's home addressing coping skills, anger management, and developing healthy relationships. Training was also provided to his mother. In-home mobile supports ended on 5/29/18. He then moved to a GH on 7/6/18, but was hospitalized due to staff interactions with him. It was a short hospitalization of two days. He stepped down to the CTH where he does well. REACH developed a crisis stabilization plan and trained the staff on 7/24/18. He transitioned back to his GH on 7/27/18 and REACH provided two sessions of staff training. He needs a day program and is quite bored during the day. REACH provided in-home mobile support in his GH for four days offering two-hour sessions. He worked on triggers, coping skills and building relationships. The final CEPP was completed on 8/15/18. REACH provided extensive in-home support, staff training and ongoing consultation. They effectively combined mobile support and the CTH to assist him through a variety of transitions and delays.

REACH reports he has been stable at his new residence for over fifty days. He has been referred to DARS and REACH connected him with an outpatient therapist.

Case Manager Interview. She reports he has made a successful transition and is doing very well. She believes that the mobile support helped him and the GH staff to create a better, more structured routine. REACH trained the GH staff. The CTH was also a positive intervention for him. REACH maintained good communication with the CM and met with her during the months of REACH service. He continues to contact REACH directly as he considers the staff as very supportive.

II-5 This individual is diagnosed with Anxiety Disorder and Down's syndrome. He was a prior REACH client. Parents requested services, as their son was becoming more verbally aggressive, increasing self-harm and destroying property. These behaviors are not exhibited at the school. Mobile supports were discussed and started in April. The CEPP was completed in June. From April through May REACH achieved the following: progress was made in some stabilization of problem behaviors; linkage to CM services; progress on the wait list and Medicaid approval. The situation at home deteriorated from June through August.

His mother reported to REACH in June that their son's negative behaviors had increased dramatically and they were now interested in pursuing a stay at the CTH. There was a one-month gap in contact with the parents by REACH. On 7/26/18 a crisis call was made to REACH and the parents were advised to call the police and request CIT officer assistance to transport him to the ED where the REACH clinician met the family. No MH stabilization or CTH bed was available so parents took him home. Parents refuse mobile supports as, "they are not what we need at this time, he needs to be out of the house". REACH facilitated contact with the CM and residential provider. The last progress note of 8/14/18 indicates the individual is still at home and situation has deteriorated further. There was no CTH visit due to bed unavailability.

REACH reported the situation remains with the individual at home and parents refusing mobile supports. When mobile supports were in place, the REACH clinician felt he was responding positively and liked to use self-expression to engage. In August the parents again contacted REACH for a CTH stay. REACH started the admission process even though no bed was available. REACH offered to coordinate ABA in the home but his family refused. They just want him moved out. The

CM recently communicated with REACH that he has still not been authorized for the waiver and remains at home.

Case Manager Interview: CM did not respond to the request for an interview

II-6 This individual, who is diagnosed with ASD and mild ID, was a prior REACH client via a non-crisis call from his mother earlier in 2018. The call resulted in mobile supports being implemented and a CEPP developed in April 2018. Notes indicate a successful outcome with a reduction in self-harm, property destruction and assaultive behavior. The progress note in May indicates that CEPP was updated due to the amount of improvement and that additional system linkage and resources were recommended. However, no updated CEPP was made available and the updated recommendations and linkages were not mentioned in the progress note. The individual was discharged from REACH on 7/20/18.

REACH reported that this was a brief and successful case. Issues were in the home and he exhibited no challenging behaviors at the school. His mother was involved in developing the CEPP and was quickly trained in its implementation. The individual is back in school after summer vacation and doing well. He was discharged in July.

Case Manager Interview: This CM did not respond to the request for an interview.

Region V

V-1 This individual is 19 years old and living at home with his family. He is diagnosed with mild ID, Schizoaffective Disorder related to anxiety, and ADHD. He was referred because of suicide ideation in June 2018. His mother threatened to throw him out of her home once he graduated. At this time REACH intervened and he was not hospitalized. He has a CM and outpatient therapy. REACH recommended linkages with a psychiatrist, DARS and mental health skill building. REACH addressed managing negative emotions, incorporating effective social skills and communication skills, and linked him with recommended community resources. He had a CEPP completed. He received three days of mobile support, but had extensive involvement with REACH during the reporting period from July through September. REACH had been in the home in the early summer helping him with coping skills and responding to his mother's request he complete household chores. His mother did make him leave the family home after his graduation from high school. He was in the ED for screening on 8/9/18 and REACH responded. He did not meet the criteria for an ECO but was kept at the hospital for one night. The CTH was not offered at the time. He has a CM but he is not on the HCBS waiver so his residential options were limited. He was placed in a boarding home and is not on the emergency waiting list for waiver services, but on the general waiting list.

Case Manager Interview: His CM reports he is doing fairly well at the boarding home. He has MH Skill Builder support and the staff work with him to find employment. She reports REACH built rapport with him and he felt comfortable with REACH staff. REACH maintained contact with the CM.

V-2 This individual is a 42-year-old man who lives in a boarding home, but has no case manager. His diagnoses include ID, Self-Injurious Behavior (SIB), and mental health symptoms. He was referred for threatening to blow up the city in which he lives, stabbing himself and verbal abuse

toward the staff. The Emergency Services Screener who was pre-screening him for hospitalization referred him to REACH on 5/5/18. The REACH clinician met him at the hospital and offered in-home mobile supports. He received four days immediately after the hospital screening, but then refused further support from REACH so no CEPP was developed.

V-3 This individual is a 21-year-old woman who lives with her family. She is diagnosed with ID (unspecified), Schizophrenia, Borderline Personality Disorder, depression and anxiety. The police contacted REACH on 5/30/18. The police were called to the home by the parents. She had taken her father's marijuana, left the house and while the parents were looking for her she returned home and locked her parents out of the house. REACH staff met the police at the home. She was able to remain at home. The REACH staff educated her on taking her medications regularly; using visual schedules and suggested coping strategies. He also provided information about the HCBS I/DD waiver. REACH attempted to visit her on 7/12/18, but she was not home. REACH called the home on 7/18/18, but was unable to speak with anyone. There is no evidence of any REACH services provided. She does not have a Case Manager.

V-4 This individual is a 23-year-old man who lives at home with his family. He was referred because of a suicide attempt in which he cut himself. He is diagnosed with ASD and depression. He was not hospitalized and stayed home. REACH recommended outpatient therapy; an autism support group; case management and continued medication management. He attends a University. REACH recommended he be offered employment during the summer when he was out of school. REACH met him after the crisis call once at school and once at his home. There was one prevention visit to assist with skill building. He completed the three days of mobile crisis with only this intervention. There was trouble with scheduling any additional appointments. No REACH assessment, crisis plan or CEPP were developed. He does not have a Case Manager.

REACH reported he rejected services after the first three days, and one mobile support session. He attends a university but may benefit from summer employment. He has numerous short-term voluntary hospitalizations. These do not involve an ED screening nor is REACH notified. When we interviewed REACH in October staff were aware he was in the hospital for a suicide attempt. The family was not interested in REACH services.

V-5 This individual is diagnosed with ASD and moderate ID. There were almost daily crisis calls, from 3/30/18 through 5/12/18, made to REACH by employees or the owner of his provider agency. REACH crisis worker responded to each call within the required time period. Every call was due to the individual's extremely aggressive behaviors, which were at times accompanied by hallucinations and delusions. Each occurrence was without the assistance of a CIT officer. The provider wanted the individual removed immediately or transported to the hospital on two occasions and on one occasion asked for a PRN medication due to inadequate staffing. The REACH worker was able to stabilize the situation each time without hospitalization. A crisis call on 5/8/18 resulted in seven consecutive days of crisis stabilization being provided by REACH. On 5/12/18 after a provider staff made a crisis call to REACH, he took it upon himself to transport the individual to the hospital. REACH staff, upon learning of this met them at the hospital and with his mother. They explained all REACH services to his mother who at the time refused services and later that same day took her son home. REACH staff followed up the next day and again offered services and again mother refused. She said she would keep him home until an appropriate group home was found.

The individual eventually moved to a new provider. REACH contacted his mother in July who reported he is doing great at his new GH. CTH services were provided during the review period.

REACH reported that the individual has been discharged given how well he has been doing at his new group home. During REACH's involvement the REACH psychiatrist completed a medication review and adjusted his medications. REACH made recommendations to the previous group home for a BCBA, individual supervision at home and in the community until a behavior plan could be established. These recommendations were ignored. No CEPP or Crisis Stabilization Plan was developed.

Case Manager Interview. The CM did not respond to the request for an interview.

V6 This individual is diagnosed with Paranoid Schizophrenia, ASD and borderline ID. He was a prior REACH client and used the CTH from 5/17/17 to 12/29/17 after a discharge from a psychiatric hospitalization. He presently resides in a group home. A crisis call came from his GH on 5/11/18 and REACH responded at his home. He had eloped. The REACH worker met with staff and parents to discuss his triggers and where to possibly look. Staff will call REACH when individual is found or returns on his own and three day follow up will begin. REACH received a call the next day that he had returned, but was still agitated. The REACH worker was on-site at group home within the required time. The REACH crisis worker was able to engage with the individual who accepted REACH services. He was able to reduce his agitation with the worker's assistance and discuss what had upset him. The CEPP was developed and executed. By the end of three visits, progress was made on identifying triggers and coping skill development was in place. Linkages that were in place were psychiatry, case management and day support. Hospitalization was avoided.

REACH reported that the individual spent time at the CTH in 2017 as a step down from hospitalization because he did not want to return home with his family. He made some serious accusations about his family while he was hospitalized. REACH assisted facilitating his group home placement. They checked on him in early October and he is doing well. His discharge from REACH is in process.

Case Manager Interview. CM reports that the individual's current situation is stable. He is doing well at the group home, attends the day program five days per week and has met with DARS recently. DARS is arranging for a job coach. The day program is preparing him for work in the community. He was recently denied Social Security benefits and the CM is challenging the decision. The individual is very healthy and has all appropriate linkages in place. He does not require any behavioral interventions. Case manager could not offer information on REACH stabilizing any crisis as he has only had this case for less than a year. He does report that REACH sent timely emails or called him when appropriate. He was aware REACH was discharging the individual.

V-7 This individual is a 26-year-old woman who resides in a GH. She is diagnosed with mild ID, Bipolar Disorder, Depression, and Borderline Personality Disorder. She is on the HCBS ID Waiver. REACH met her at the hospital for a TDO screening. There was an incident at the GH and the staff requested a TDO screening. She did not meet criteria, but could not return to the GH as staff was seeking a protective order. REACH helped her to arrange to stay with friends. REACH staff worked with the GH staff to help her return and staff training on three occasions. They were

also available by phone. No REACH assessment, crisis stabilization or CEPP were developed because she refused to schedule or participate in the evaluation.

REACH reports she is an active case again as of the fall and a visit was made with her on 10/9/18. She moved to a new GH under a new provider in September. The staff are working effectively with her and do not need training by REACH.

Case Manager Interview: The CM did not respond to the request for an interview

V-8 This individual is diagnosed with Bipolar Disorder, Paranoid Schizophrenia, Anxiety Disorder, and mild ID. REACH involvement began 6/22/18 with this individual when GH staff contacted REACH for an assessment. A stabilization crisis services plan was developed on 6/22/18. Services requested by GH were: in-home mobile supports, crisis intervention and crisis stabilization. The individual was identified as being at risk for psychiatric hospitalization and of losing her community placement. She has a history of psychiatric hospitalizations from 2009 through 2016 and served a prison sentence from June 2011 to January 2012.

The call was precipitated due to escalation of crisis and associated behaviors. She was banging her head on floor and walls, screaming, pacing, laying on ground/road refusing to get up, and refusing her medications. She is dually diagnosed and has a diagnosis of paranoid schizophrenia with active delusions and hallucinations. Her delusions and hallucinations often take the form of accusations against staff. In addition, she has a history of suicidal statements and gestures during crises. There were five responses to crisis calls by REACH from July through August 2018. CIT police were involved in two of the calls and hospitalization was avoided in all cases. The crisis on 8/25/18 resulted in an ED screening and the individual returned home that same day.

The CEPP was developed. REACH recommended MH skill building services; day support program; case management; outpatient services for long term trauma related therapy; and support with continuation of psychiatric services with training for GH staff in order to maintain consistent psychiatric appointments.

REACH reported that she remains an active case. The individual resides in a poorly staffed group home. The manager of her home has declined all recommendations made by REACH. The individual is constantly in a state of crisis. The CM is not responsive to REACH and is not involved with the individual. She does very well in response to being out in the community as it positively affects her mood and behavior. The group home staff never brings her to the community and therefore trigger constant crisis.

Case Manager Interview: CM reports that she is no longer the individuals' case manager but was through July 1st. Case Manger was aware that individual currently resides in a group home. Through reporting period after REACH involvement individual was stable and had no crisis once stabilized. Day Services were lost during the reporting period due to the need for a 2:1. Recreation therapy was being provided at 40 hours per month. Psychiatry was in place through June as was PCP. CM was not able to remember if behavioral support was in place.

V-9 This individual is diagnosed with mild ID. REACH responded to a crisis call on 5/21/18 from the individual's mother. She reported that her daughter had knives and was threatening to stab herself and her mother. Mother had left the home to make the call and also reported that the individual had locked all doors and would not open them for anyone. There is no mention of a CIT officer involvement. REACH responded within the hour.

The REACH crisis worker reports that she was able to engage easily with the individual who was fully aware. She had no homicidal or suicidal intent and showed no ideation. The REACH worker was able to determine that the trigger to the event was that she was frustrated and overreacting to the fact that she had run out of medication for a gastrointestinal disorder. The REACH worker suggested they all walk to pharmacy and retrieve prescription. The time to walk allowed the REACH worker to engage further with her and her mother and to develop a plan to accommodate her request to go to the pharmacy counter on her own and ask for and receive her prescription which was accomplished. The REACH worker completed an Adult Safety Agreement with her and set up three days of mobile supports. There was no documentation that the three scheduled visits occurred. There was documentation of an attempt to schedule an Assessment on 6/22/18.

It is important to note that a hospitalization was avoided and the initial crisis intervention was thorough. Recommendations beyond three days of mobile support were: day treatment or DARS supported employment; independent living skills (ILS) development; and family counseling to develop effective communication between mother and daughter. Linkages in place were psychiatry and psychology services. REACH reported that they were in the process of discharge. She has refused services. The individual called on 9/11/18 to cancel scheduled services for that week and then rejected services altogether.

Case Manager Interview: The CM did not respond to the request for an interview

Section B Children

I-11 This child, who is diagnosed with Disruptive Mood Disorder and ADHD, had his initial involvement with REACH was on 5/15/18. REACH provided crisis stabilization and prevention. He spent minimal time at a stabilization unit. His mother voiced concerns regarding the effectiveness of interventions and removed her son from stabilization. He was discharged on 7/30/18 after repeated attempts to contact the mother went unanswered.

REACH reports the individual did fairly well at school but had significant struggles at home that resulted in multiple hospitalizations previous to REACH involvement. A CEPP was developed before other REACH services were discontinued. No Crisis stabilization plan was provided.

Case Manager Interview: The CM did not respond to the request for an interview.

I-12 This child is diagnosed with ADHD, Oppositional Defiance Disorder, and ASD. REACH's contact with this child and family appeared to be brief given the brevity of progress notes. He pulled a knife on his mother and was brought to the ED. He was hospitalized for six days. REACH was present for the hospital screening. Intervention and prevention work began by REACH on 5/23/18 and went through to 6/20. Goals and objectives looked appropriate on his plan, but the progress notes did not indicate the level of success. A CEPP was developed for him. REACH reports he was discharged in July due to REACH's continued inability to contact his father. They indicated that the school filed a Child Protective Services (CPS) complaint in late June. The father then stopped answering calls. REACH indicated that parents were doing wonderful work and following plan developed up until that point.

Case Manager Interview: The CM did not respond to the request for an interview

I-13 This child is diagnosed with PDD and major Depressive Disorder. REACH became involved on 4/3 when they met with the parents for discharge planning from his most recent hospitalization. The progress notes REACH provided were minimal and there was not much contact although a CEPP was developed. There was no crisis stabilization plan. There is no case manager.

REACH reported the mother and daughter could not be located. REACH went to the home to provide services and the home was vacant. Upon finally reaching mother after many attempts she said she forgot to call and tell them the family was moving. The family no longer resides in the region.

I-14 This individual was referred to REACH on 4/19/18 because he made homicidal threats to a classmate; has been physically and verbally aggressive and is at risk of hospitalization. His mother has trouble setting limits and he is reacting to losing his intensive in-home (IIH) staff. His diagnoses include ADHD, ASD, and a mood disorder. He is only six years old.

REACH conducted a crisis stabilization assessment. REACH planned to address appropriate peer relationships; identifying and verbalizing feelings appropriately; and developing coping strategies. He received one to six hours per day of in-home crisis services between 4/20/18 and 4/26/18 from the REACH Coordinator. The Coordinator used art therapy, play therapy, mindfulness, cinematic sessions and role modeling to address goals. The CEPP was developed. REACH recommended resuming mental health support; case management; a therapeutic day treatment program; psychiatrist; and continued REACH support. REACH called his mother on 5/6/18. She declined the opportunity to continue REACH services. He regularly uses the crisis stabilization unit and outpatient services of the CSB. The family is not interested in in-home supports.

Case Manager Interview: His CM is now a CM supervisor, but was the CM at the time of REACH services. The family made a referral directly to REACH, but did not inform the CM at the time. The CM had minimal contact with REACH and does not know the family's satisfaction with REACH support. REACH staff did contact the CM to let him know that the family did not want further assistance. The child is stable and is doing well in school. His community supports remain in place. The CM does not believe he would benefit from a behaviorist, nor did REACH recommend one for this child.

I-15 This individual was referred on 5/7/18 for MH Crisis Intervention and REACH prevention and was assessed 5/14/18. MH Crisis Intervention was recommended for seven days and REACH Prevention was recommended to start and be ongoing for ninety days. He was referred for making

suicidal threats at school and also homicidal ideation. He is six years old and diagnosed with ADHD, ASD (rule out), and a communication disorder. He lives with his mother, but his remaining at home was in jeopardy as he was at risk for hospitalization. He has been hospitalized in early 2018. A treatment plan was developed to help him develop coping and communication strategies, and for the family to develop skills to intervene positively. He received crisis intervention through 5/18/18. His REACH staff met him at the school and provided six hours of support daily. They provided coping skill training, communication skill development, mindfulness exercises, Cognitive Behavioral Therapy (CBT), identifying emotions, and understanding consequences of behaviors. A CEPP was developed. There is no evidence that the family was trained by REACH staff, but the mother needed to place supports on hold in June. She and her sons were displaced because of a fire in their home. REACH continued to check in with the family through 7/30/18. He was doing well and playing football. He moved to a different apartment in his building. He maintained outpatient therapy.

Case Manager Interview: His CM reported that REACH was very helpful. The REACH services helped him to stabilize and he had a positive summer. REACH coordinated with the CM and stayed in communication. He transferred to a supportive therapeutic school this fall and is having difficulty adjusting. He continues to do well at home and to participate in outpatient therapy. The CM said a BCBA might be helpful as a resource to the school.

II-7 This child is diagnosed with OCD and ASD. He started REACH services in January 2018. Documentation does not indicate if services began due to a crisis or non-crisis event. Mobile supports were put into place on 4/3/18 with a plan for five 2-hour sessions over a two-week period. The crisis stabilization plan was developed on 4/1 to address aggressive behavior and sudden mood shifts with aggressive episodes having duration of at least one hour. Mobile service sessions were provided through 4/19/18.

There appears to have been no contact from 4/19/18 to 5/25/18 when the REACH clinician called to get an update. Mother let the clinician know that Applied Behavioral Analysis (ABA) had been in place for one week and that was what they wanted for their son. In-home support was in place. The mother found the CEPP to reflect strategies the family had already tried. The family was not interested in REACH providing any training on the CEPP. Parents were involved in the CEPP development. REACH reported that attempts to contact the family since May have not been successful. The individual is presently listed as inactive but will move to discharge status soon. This child does not have a Case Manager assigned

II-8 This child is diagnosed with Agoraphobia with Panic Disorder, CP, ASD and an intellectual impairment. She was introduced to REACH in March 2018 through a non-crisis call. On 4/2/18 a non-crisis visit to her home by REACH was conducted to explore the need for mobile supports. Three days later a crisis call was received by REACH, which was able to de-escalate the situation over the phone. Mobile supports were started on 4/16/18 and conducted through 4/19/18. REACH checked in by phone weekly through 6/26/18 and monthly until 8/1/18. A provisional Crisis Plan and CEPP were developed. A progress note stated that an updated CEPP was developed and sent to the mother on 5/24/18 but there is no documentation of the updated CEPP in our records.

She attends school and has a PCP. REACH recommended linkages for psychiatry, ABA and intensive in-home support (IIH). REACH arranged for the IIH evaluation. She was found to be

ineligible for this service. Progress notes indicate that the PCP wrote prescriptions for new medication, in home therapy and PT on 5/8/18. REACH monitored through weekly phone calls until 6/1/18. The family reported she was making major improvements in her behavior. REACH continued calls to check in over the past three to four months. She continues to do well. She was recently moved to inactive status.

Case Manager Interview: The CM did not respond to the request for an interview.

II-9 This child, who is diagnosed with Anxiety Disorder, ADHD, and ASD, was referred to REACH in January 2018. However, the record does not indicate the source of the referral. Intake took place in February and the first contact with REACH was 4/2/18. A few appointments were rescheduled at the mother's request due to illness and conflicts. The first face-to-face visit was on 4/26/18. CEPP development took place on 5/1/18 and was followed by mobile supports provided through 6/1/18. REACH recommended in-home therapy, ABA and WRAP. The linkages in place at the initial contact were school and the PCP.

REACH mobile supports and implementation of the CEPP were quite successful as evidenced by continued stabilization within the home environment; development of coping strategies; and a reintroduction of the individual to community activities. The family decided to move to Boston where many more services are available for their son. REACH recommended the family share the CEPP with his future providers to continue to build on the success that he had achieved. REACH reported that his mother worked closely with REACH to identify providers in the Boston area. REACH assisted her in making the final choice of new providers for her son. In addition, his mother requested REACH provide information and consultation with the Boston provider, which was done. The individual made a good transition and is reported to be doing very well.

V-10 This child is diagnosed with ASD. REACH received a call on 5/29/18 from someone at the Children's Clinic stating that this individual had written homicidal thoughts in her "feelings' journal". She had specifically mentioned seeking this type of revenge on her family and boyfriend. The screener requested REACH. The REACH clinician arrived at the clinic within two hours and was able to engage with the individual and her mother. REACH services were accepted, follow up mobile support was scheduled to begin the next day, and hospitalization was avoided.

No documentation was present that immediate mobile support was provided but there is documentation of mobile support in August 2018. There was no evidence of a safety plan, crisis stabilization plan or CEPP. There is no evidence that the linkages REACH recommended: psychiatry, case management, ABA and counseling were developed.

REACH reported that the individual has been stabilized and remained stable for more than ninety days. All recommended linkages are not in place. Her mother has tremendous difficulty following up. REACH continues' to try to assist this family. Linkages in place are school counseling, outpatient counseling at the CSB, and a PCP. Linkages not in place are psychiatry and case management.

V-11 This child is diagnosed with ASD, ADHD, and unspecified emotional and behavioral disorders. Documentation shows a brief period of involvement with this individual. The start date was 4/12/18 and discharge date was 7/30/18 with last contact made on 6/22/18

REACH notes indicate multiple crises due to aggression, threatening behaviors and inappropriate sexual gestures. REACH involvement began when the individual pulled a knife on his grandmother as well as kicked her and spit at her. Notes also indicate no significant progress was made with treatment due to the short period of service. The CEPP had been completed in 2016 but could not be updated as attempts to meet were consistently thwarted by loss of contact and the cancellation of appointments. Loss of contact with the family was cited as the reason for discharge. REACH reported that the father was very inconsistent returning calls and repeatedly cancelled sessions. REACH lost contact with his father in June but continued attempts to make contact through July. REACH stated they were using a 2016 CEPP until they could update with his father and grandmother.

Case Manager Interview: The CM did not respond to the request for an interview.

V-12 This child is diagnosed with ADHD and other Developmental Disorders. His mother placed a crisis call to REACH on 7/14/18 and reported that her child was hitting her and out of control. REACH responded at the home and the REACH worker was able to engage with the child and bring the situation to a normal level with good response from the child and mother. REACH services were accepted with follow up visits scheduled for 7/15/18 and 7/16/18. There is no record of those visits taking place or being re-scheduled. There is record of a visit on 8/1/18. There is no record or progress note of any other contact until 8/6 when the mother placed another call to REACH. Call was deemed a non- crisis call with follow up appointment scheduled for 8/10 at the family home. Mother called on 8/10/18 to reschedule visit. No record of new follow up date in the records submitted.

Linkages in place are psychiatry and counseling services. The Provisional CEPP was developed and makes good use of positive behavioral supports. Also, the action plan for crisis is clear and concise. Hospitalization was avoided.

REACH reports they are still involved but mother does not follow up well or keep appointments. They have attempted to have the individual seen by a psychiatrist at the CSB, but mother is covered by Tri-Care and CSB is reluctant to provide this service.

Case Manager Interview: The CM reported that she only did intake for this individual and does not know who the current CM was. The CM does not recall any involvement with REACH. The individual's mother decided she would find a community provider herself and started with Genesis Counseling Services. The Case Manager said she has never interacted with REACH on any case.

V-13 This child is diagnosed with ASD and ADHD. This young man was a participant of REACH prior to the review period. The first contact in this review period was the result of his attack on his wheelchair bound mother that resulted in an ECO screening. Individual stayed the night in the ED but did not meet criteria for hospitalization. Documentation shows a recent brief stay at a stabilization unit. He attacked his mother three more times between July and August. The CIT was helpful calming the situation on two of these occasions, once before REACH arrived. REACH was always involved and was able to arrange for a new provider after the third attack. Hospitalization was avoided at each instance. REACH provided a timely in person response in each instance.

REACH reports the individual has moved to a new foster home and that he is adjusting well. He has been stable for more than one month. The foster home is working with a “Parents with Autism Group”, that was facilitated by REACH. REACH will soon begin the discharge process. No CEPP or Crisis Stabilization Plan was developed.

Case Manager Interview: The CM reports the individual is stable and doing well at a group home. There has been no assaultive behavior for approximately 2.5 months. A behaviorist was in place for a while but due to distance stopped providing services. CM is close to having another behaviorist in place. The CM also reported that REACH involvement, during multiple crises, prevented ED visits and potential hospitalizations. She reports that her contact with REACH is monthly via phone and in person.

V-14 This child is diagnosed with ASD, mild ID, and ADHD. Documentation shows a brief period of involvement with this individual in 2017. There were two crisis calls in this reporting period: one from the police and one from the CSB. REACH provided three follow up mobile support stabilization visits and two prevention visits in May and June. REACH’s response to the crisis calls avoided the screening for hospitalization. No CEPP or crisis stabilization plan was developed.

REACH reported that the last contact was in June when the grandmother called to discontinue services. Linkages were case management, psychiatry and outpatient therapy that were in place prior to this reporting period.

Case Manager Interview: The CM did not respond to the request for an interview.

V-15 This child is diagnosed with ASD and ADHD. A CIT officer made a crisis call to REACH on 5/3/18. He stated the crisis particulars that included that EMS had been called for transport, but that the mother has refused to allow them to transport him to the hospital. The REACH clinician arrived within the required time period and was able to deescalate the situation and avoid hospitalization for the individual. There were three follow-up visits for mobile support scheduled in May, but only one occurred on 5/5/18. The crisis stabilization plan and CEPP were developed 5/14/18.

His mother reported to REACH that Virginia Behavioral Health was delivering psychiatric services until very recently when the psychiatrist refused to see her son any further. Recommended services by REACH are: psychiatric, REACH Prevention, intensive in-home supports (IIH), case management and ABA. The only support he had at the time of the referral was respite. He does not have a CM

REACH reported making many attempts to contact his mother. Upon finally reaching her she reported she had fled with her daughter to escape her abusive husband. She would not disclose her location, but said she would contact them once she was settled, as she wanted to continue with REACH in the area she would live.

V-16 This child, whose has diagnoses of ASD, ADHD, OCD and PTSD, was previously known to REACH. On 4/21/18 Kempsville Behavior Center contacted REACH to come to their assistance in order to avoid transporting this child to the hospital. The REACH clinician arrived within the required time frame and was able to avoid a hospitalization. His mother agreed to REACH mobile crisis services. Appointments were scheduled in April, but there was no evidence that those appointments took place. REACH notes indicate the individual had built a rapport with REACH clinicians and that he was responding to the plan and beginning to use replacement behaviors.

His mother called on 6/1/18 and requested discharge from REACH. She stated she had been successful in past without MH/DD services. In addition, that she expressed fear of a CPS allegation for physical abuse would be filed, as she and her husband did not trust REACH clinicians.

Recommendations by REACH were: ABA Therapy, Family Therapy, Mobile Supports, continue with Case Management, medication management done by the PCP and continue to use CEPP. REACH reported the individual has been discharged at his mother's request. She would not follow any recommendations the REACH team made.

Case Manager Interview: The CM did not respond to the request for an interview.

APPENDIX D.

**REVIEW OF THE
INTEGRATED DAY AND THE EMPLOYMENT SERVICES
REQUIRMENTS**

BY: Kathryn du Pree MP

**2018 REVIEW OF THE INTEGRATED DAY AND EMPLOYMENT
SERVICES REQUIREMENTS OF THE US v COMMONWEALTH
OF VIRGINIA'S SETTLEMENT AGREEMENT**

REVIEW PERIOD: OCTOBER 1, 2017- SEPTEMBER 30, 2018

**SUBMITTED TO DONALD FLETCHER
INDEPENDENT REVIEWER**

**BY: KATHRYN DU PREE, MPS
EXPERT REVIEWER
October 24, 2018**

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I. OVERVIEW OF REQUIREMENTS

Donald Fletcher, the Independent Reviewer has contracted with Kathryn du Pree as the Expert Reviewer to perform the review of the employment services requirements of the Settlement Agreement for the time period 10/01/17 - 9/30/18 the twelfth and thirteenth review periods. The review is the first time that the review period has been lengthened to a year, instead of six months. Virginia has been implementing progressive changes to its integrated day and employment service array for individuals with intellectual and developmental disabilities (I/DD) since 2012. The Independent Reviewer determined it is more useful to review the relevant data over a twelve-month, rather than a six-month, period to provide a greater understanding of the advances that are being made and to provide a longitudinal view of the pattern of accomplishments from the Commonwealth's efforts to address challenges and implement policy and funding changes. This report includes data and findings of the Commonwealth of Virginia's progress toward achieving the following requirements:

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

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

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

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

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

2. *Targets to meaningfully increase:*

- a. *The number of individuals who enroll in supported employment in each year; and*
- b. *The number of individuals who remain employed in integrated work settings at least 12 months after the start of supported employment*

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

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

II. PURPOSE OF THE REVIEW

This review will build off the review completed last fall by the Independent Reviewer for the eleventh review period 04/01/17 through 9/30/17 and the related recommendations the Independent Reviewer made in his last Report to the Court.

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

- The refinement of the implementation plan to increase integrated day activities for members of the target population including the strategies, goals, action plans, interim milestones, resources, responsibilities, and a timeline for statewide implementation;
- The expectation that individuals in the target population are offered employment as the first option by Case Managers and their teams during the individual planning process in which they discuss and develop employment goals;
- The Commonwealth's success meeting the FY 2018 targets it set for the number of people, members of the target population, who are in supported employment, the number who remain employed for at least twelve months, and the average earnings for those in supported employment;
- The exchange of information regarding employment accomplishments and barriers between the Regional Quality Councils (RQCs) and the Employment First Advisory Group (E1AG); and
- The Commonwealth's progress to offer community engagement and community coaching to individuals who do not work or as a supplement to their employment.

III. REVIEW PROCESS

To complete this review and determine compliance with the requirements of the Settlement Agreement, I reviewed relevant documents and interviewed key administrative staff of DBHDS, and members of the Employment First Advisory Group (E1AG), previously known as the SELN-Virginia. In July 2018, prior to initiating this review, a kickoff meeting was held with the Independent Reviewer, the Expert Reviewer, Heather Norton, Peggy Balak, Jenni Schodt and Anita Mundy to review the process and to clarify any components. The Commonwealth was also asked to suggest ways the methodology of the planned review could be improved and to provide any additional documents that it maintains to demonstrate that it is properly implementing the Settlement Agreement's provisions related to integrated day and employment services.

Document Review: Documents reviewed include:

1. VA DBHDS Employment First Plan: FY 2016-2018, updated through FY18 Q4
2. DBHDS Semiannual report on Employment (draft): 09/24/18
3. SELN Work Group meeting minutes relevant to the areas of focus for this review. The SELN now includes two advisory groups: the Employment First Advisory Group (E1AG) and the Community Engagement Advisory Group (CEAG).
4. Regional Quality Council (RQC) meeting minutes and recommendations for implementing Employment First
5. Statewide Quality Improvement Committee Meeting Minutes:
6. Community Engagement Plan FY2016-2018, updated through FY18 Q4
7. Outline for Family Listening Session
8. Memorandum of Agreement (MOA) between DBHDS and DARS: 7/1/18
9. Memo from DBHDS and DARS to CSBs, ESOs, DBHDS Staff regarding the DBHDS/DARS MOA: 8/10/18
10. Temporary Instructions for Coordinating Transportation Requests form DBHDS: 7/25/18
11. Employment Options Discussion Guide for Case Managers
12. Employment Frequently Asked Questions(FAQ) for Case Managers
13. Employment FAQs for Families and Individuals

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

IV. THE EMPLOYMENT IMPLEMENTATION PLAN

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

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

DBHDS, with the input of the E1AG (formerly the SELN-VA Advisory Committee) has revised the FY16-FY18 plan to increase employment opportunities. I was provided with the Status Report as of 6/30/18. The Plan includes five goal areas each of which has sub-goals.

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

Status: The DBHDS, Department of Aging and Rehabilitation Services (DARS) and Department of Education (DOE) efforts continue to be in the planning stages. DBHDS, DMAS, DARS, and DOE re-established the interagency workgroup and met at least twice during the review year. The focus of the workgroup is on data sharing, joint trainings, funding arrangements and effective communication. The MOA was developed between DBHDS and DARS to authorize the use of waiver funding when DARS had to initiate an Order of Selection so individuals do not experience a delay in employment support. DBHDS and DOE developed a Memorandum of Understanding (MOU) to collaborate to advance employment initiatives for elementary and middle school youths to explore pathways to employment.

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

Status: Progress has been made in benefit planning although there is a delay in adding it as a waiver service. A list of benefits planners was compiled but posting of this material was not reported as having been completed. The training subgroup is developing a process flow for transitioning students and is compiling success stories to publicize on the DBHDS website for families. DBHDS, DARS, DOE and Department of the Blind and Visually Impaired (DBVI) collaborated to provide Customized Employment training and certification to over 200 supported employment providers.

Goal 3: All employment services are in alignment with evidence based/informed best practice and federal/state regulatory requirements.

Status: The Policy Group reviewed existing vocational policy to develop fact sheets for providers. The Policy Group is a standing sub-committee of the E1AG. E1AG members volunteered to serve on the sub-committee. The Group issued a series of questions to ascertain fears and misconceptions about employment policy that may be halting employment support development among Employment Service Organizations (ESOs). This survey was combined with the survey referenced under Goal 4. Fifty-one providers responded to share concerns regarding transportation and descriptions of service gaps. The Group completed FAQ's for Case Managers (CM), which is under final review before disseminating.

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

Status: The Data Group worked throughout the year to develop and conduct a survey on provider capacity and transportation in order to identify gaps in service. The data subgroup also reviewed the past three employment reporting periods to identify trend information. A report is underway but was not completed.

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

Status: Three new Employment Service Organization (ESO) members were recruited and appointed to the E1AG. Membership will change in the 2018-2019 year so that all disability groups are represented.

Conclusion and Recommendations: DBHDS is meeting the provisions of 7.b.i.A. DBHDS provided significant community engagement training during this reporting period, as is reported later in this report. DBHDS and DARS partnered with the University Center for Excellence in Developmental Disabilities (UCEDD) at VCU to provide over 200 employment staff with Customized Employment Training. DBHDS and DARS have provided technical assistance to ESOs. DBHDS has planned and started a series of Family Listening events that are being held across the state during the fall of 2018.

This is a critical time in the Commonwealth's implementation of its employment first initiative. The Commonwealth, with the contributions of many stakeholders, completed much of its planned work that it projected was necessary to reach its employment targets: rate changes, service definitions, provider incentives, meaningful and consistent data reporting, initial training, and interagency collaboration, especially between DBHDS and DARS. These changes were all intended, at least in part, to contribute to significant increases in the number of HCBS waiver funded participants in supported employment. The Commonwealth is realizing an increase in the number of participants in Individual Supported Employment (ISE), which is discussed in greater detail in Section V of this report. DBHDS and DARS took action during this review period to:

- Address the impact of waiting lists for DARS services for waiver participants;
- Pilot the implementation of transportation services to enhance employment; and
- Better inform and educate families and individuals about the availability of employment support.

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

Annual baseline information regarding:

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

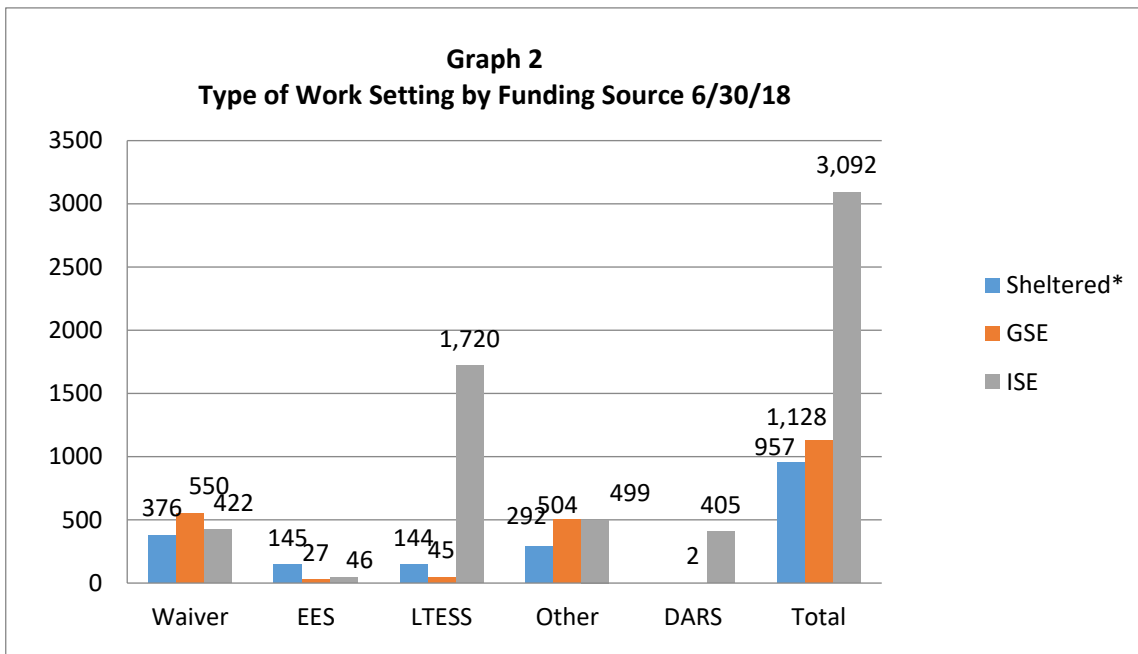
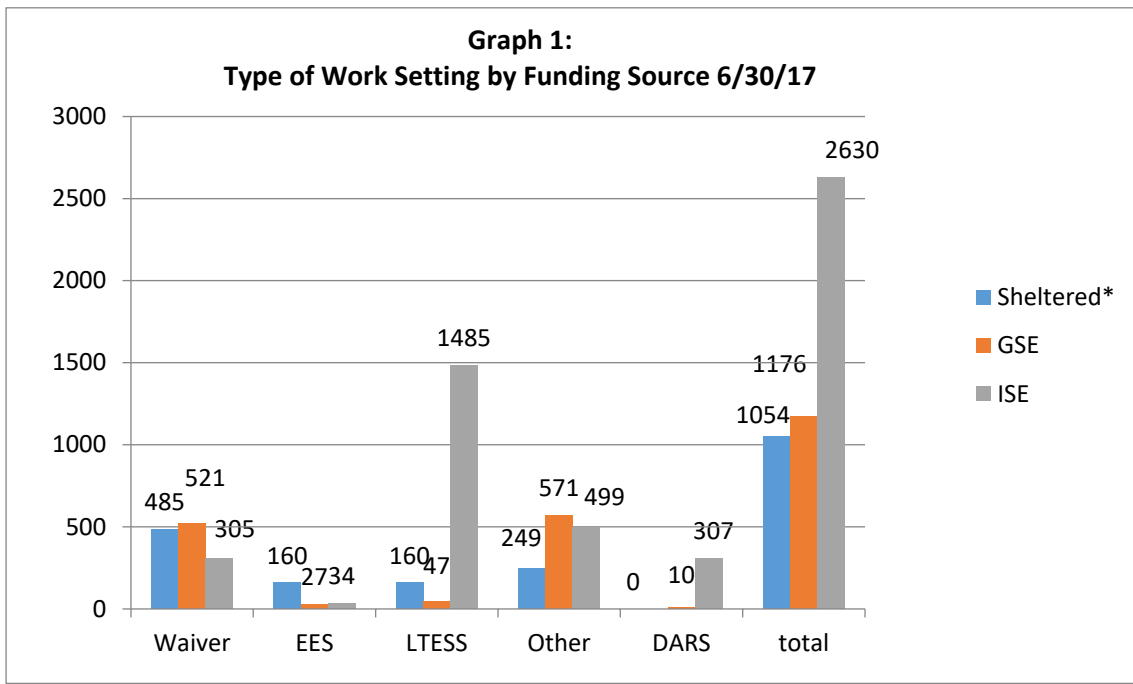
DBHDS has worked in partnership with the DARS to refine its data collection since October 2014. DBHDS had a response rate of 44% at that time. The DBHDS provided two semiannual reports on employment for this review. One summarizes December 2017 data and the other summarizes June 2018 data. The DBHDS Semiannual Report on Employment dated September 24, 2018, is the fifth semiannual reporting period in which responses were received from 100% of the ESOs.

DBHDS continues to gather data from a second source for both Employment Reports. DBHDS used its data sharing agreement with DARS to gather data regarding individuals with developmental disabilities who receive Extended Employment Services (EES) and Long Term Employment Support Services (LTESS). Both of these employment services are funded by DARS. The consistency of data reporting from both DARS and the ESOs make it possible to make comparisons between reporting periods.

Statewide Employment Data Analysis-This report compares the achievements in employment between June 2017 and June 2018 a full year, rather than a six-month time period. The data in Graph 1 below for June 2017 indicates that 2,630 individuals were in Individual Supported Employment (ISE) services and 1,176 were in Group Supported Employment (GSE) services. An additional 1054 people were receiving services in sheltered workshops. The individuals in sheltered workshops are not counted toward the DBHDS employment targets. As of June 2018, the numbers of individuals in these three situations changed when compared to June 2018, as follows:

- 462 more individuals were employed in ISE
- 48 fewer individuals were employed in GSE
- 97 fewer individuals in sheltered work

Overall, in June 2018, there were an additional 414 individuals were in supported employment with the gain evidenced in ISE. These numbers reflect the total number reported as employed across all employment programs including the programs offered by DARS as well as the HCBS waiver employment services.



Graph 2 depicts the status of employment for individuals with disabilities in June 2018. Overall, 4,220 people are employed with supports from ISE and GSE, which is an increase of 414 people from the data reported in June 2017. It also indicates that 972 individuals on the waiver are employed, which represents 24.55% of all individuals on the waiver. This is an increase from the

previous year when DBHDS reported that 23% of the individuals on the waiver waiting list or enrolled in a waiver were employed. It is important to note that waiver-funded ISE employment increased by 117 people which is a 38% increase in ISE for waiver participants during the past twelve-month period. Overall participants in the waiver program who were employed increased from 826 at the end of June 2017 to 972 participants in June 2018. This is an overall increase in employment of 17.5% in the waiver programs in the most recent twelve-month period.

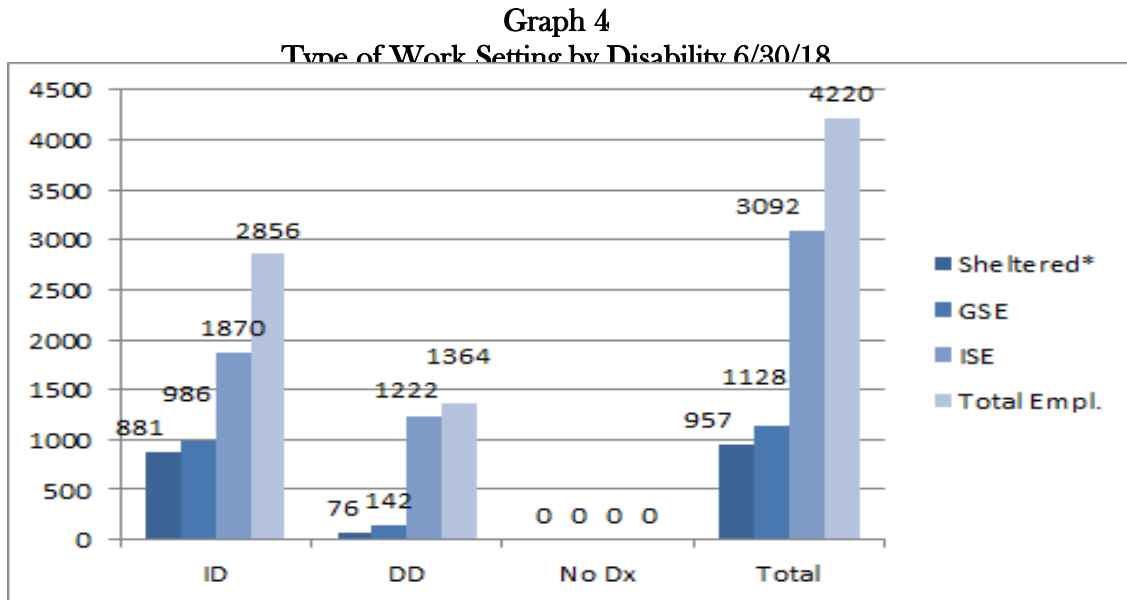
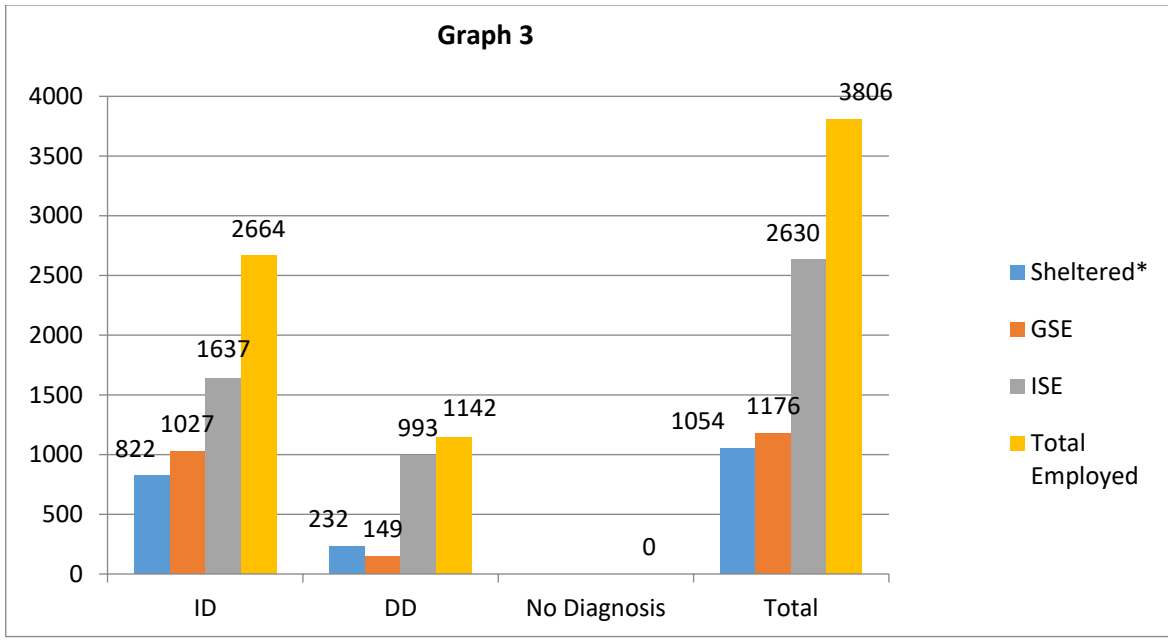
DBHDS has been able to sustain the accuracy and comprehensiveness of the employment data in terms of the overall number of individuals with disabilities who were employed. Once again 100% of the ESOs reported on the number of individuals employed who were waiver participants.

DBHDS continues, as it should, to report on the number of individuals employed in ISE and separately the number in GSE. The long-term goal of the Settlement Agreement, however, is to have individuals employed through ISE and eventually competitively employed. Overall, of the individuals in supported employment in June 2018, in either ISE or GSE, 73% were employed in ISE, compared to 69% in June 2017. Again the DARS LTESS program funds the majority of individuals in ISE. Of the total number of individuals in ISE, 14%, compared to 12% in June 2017 are participating in the HCBS waiver-funded employment services. Of individuals in HCBS waiver-funded ISE, the number increased by 117 individuals between June 2017 and June 2018. During this period, the number of individuals in GSE decreased by fifty individuals across all of the employment programs. However, the participation in GSE increased by twenty-nine participants in the waiver program. Previously a decrease had been seen in waiver GSE participation.

The number of individuals in the sheltered workshops (SWs) is not counted by DBHDS towards the employment target goals. However, it is important to track the changes in utilization of the workshops. Fewer individual should be in SWs as a result of the changes DBHDS made in the waiver service definitions. The Commonwealth did not plan to have SWs in the waiver at all by July 2019 to make sure Virginia was fully compliant with the federal Workforce Innovation and Opportunity Act (WIOA). While we have seen an increase in the use of sheltered workshops in past reports, during this reporting period it is heartening to see a decrease in the number of individuals in sheltered workshops overall and in the waiver workshops specifically. The number in waiver sheltered workshops decreased by 109 people, and by 97 people overall. Sheltered work decreased in the ESS and LTESS programs in addition to the waiver program but did increase in the “Other” category lessening the overall reduction in the total number of people in sheltered workshops.

Employment of individuals by disability group- Overall there are increases in the numbers of individuals employed with either ID or DD between June 2017 and June 2018. There was an increase of 222 individuals with DD who were employed by June 2018, and an increase of 192 individuals with ID who were employed at the same point in time. This represents a 19% increase in employment for individuals with DD, and a 7% increase in the employment of individuals with ID. Both disability groups decreased their use of GSE. Overall 48 fewer individuals used GSE. Also fewer individuals were in sheltered workshops. However, while the number of individuals with DD in sheltered work decreased from 232 to 76, the number of individuals with ID using sheltered workshops actually increased from 822 in June 2017 to 881 in June 2018. This is an increase in participation of 7% of the ID group.

Graph 3 shows the employment involvement of individuals by disability group (individuals with Intellectual Disabilities (ID) and those with Developmental Disabilities, other than ID). Graph 4 describes the same data for June 2018.

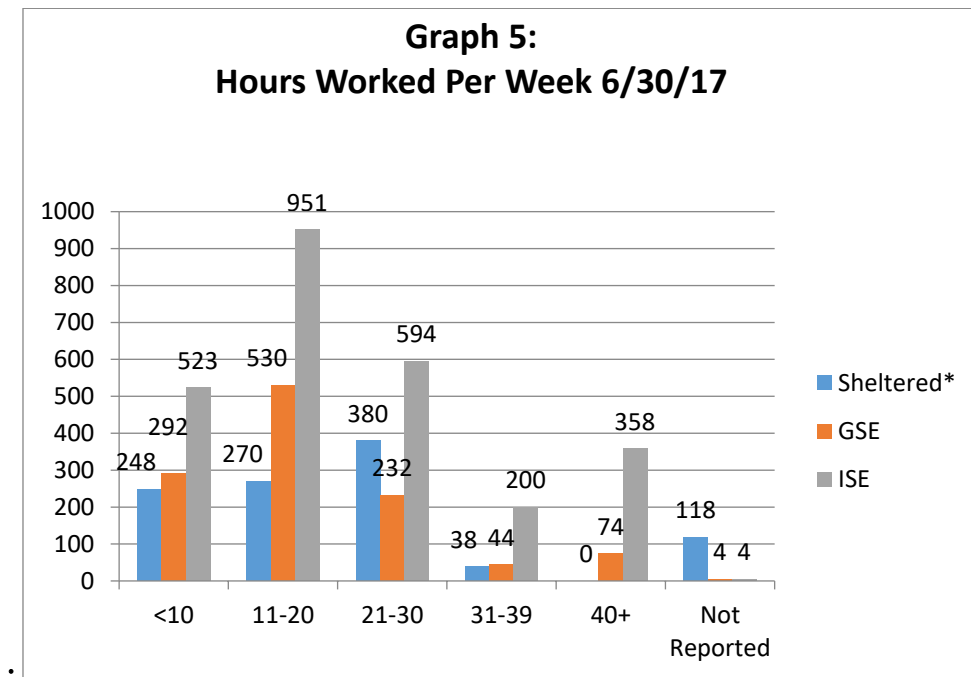


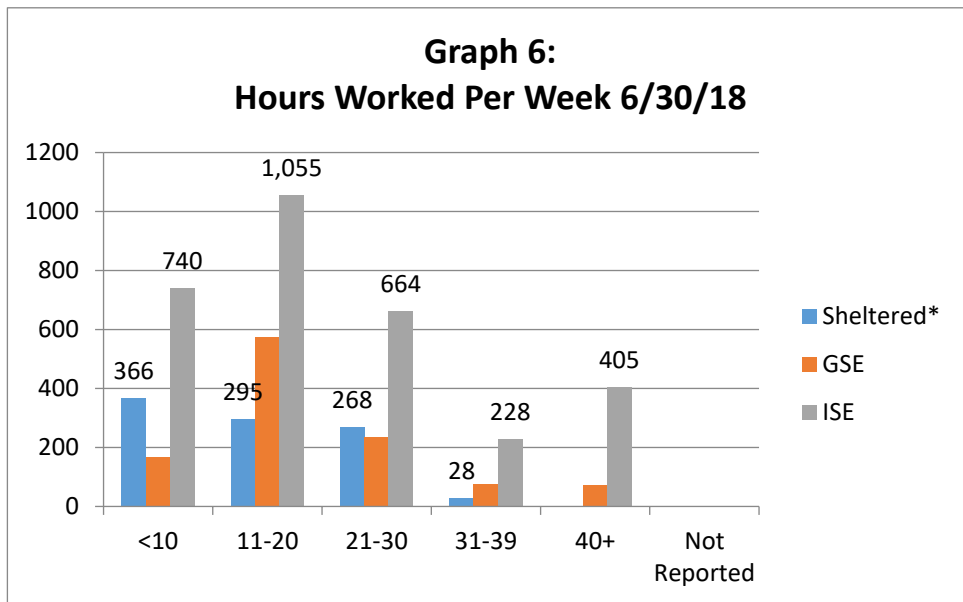
* not counted toward total

Average hours worked The Commonwealth no longer reports these data separately by ID and DD target groups or by Region. Previously individuals with DD worked more hours on average than did their counterparts with ID. Comparisons of both data sets had been useful as they provided more detailed information about potential areas of under employment and geographic disparities. Graph 5 below details hours worked by service type in the DBHDS Semiannual Employment Report as of June 2017. Graph 6 depicts this information as of June 2018.

There has been an increase in the number of individuals who receive employment support who work twenty hours or less per week when comparing the data from June 2018 to the data from June 2017. Fifty-eight compared to fifty-six percent of individuals with IDD who receive employment support services work twenty hours or less per week in ISE. In GSE the percentage of individuals working twenty or fewer hours per week increased from 70% of the population to 72%.

Between June 2017 and June 2018, the percentage of individuals reported as working thirty hours or more per week in ISE *decreased* from 21% to 20% and from 10% to 9% in GSE. However, the number of individuals in ISE working either 31-39 or forty or more hours per week *increased* by twenty-eight and sixty-seven individuals respectively in the thirteenth reporting period. DBHDS still does not report on whether individuals are working the number of hours they want to be employed. Many of the individuals may be underemployed. This is determined based on the fact that 62% (2585 of 4187 individuals) are working no more than twenty hours per week.



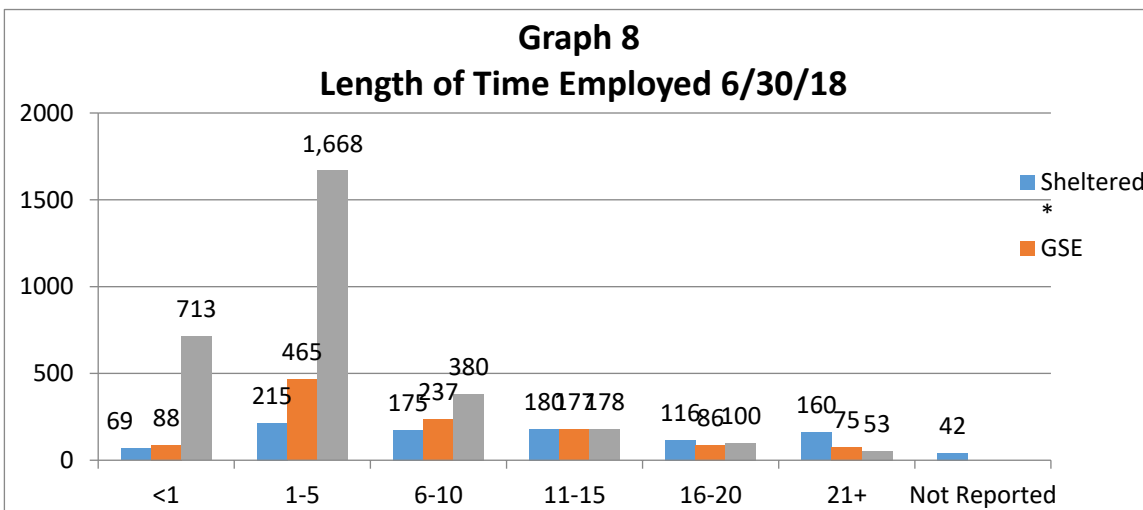
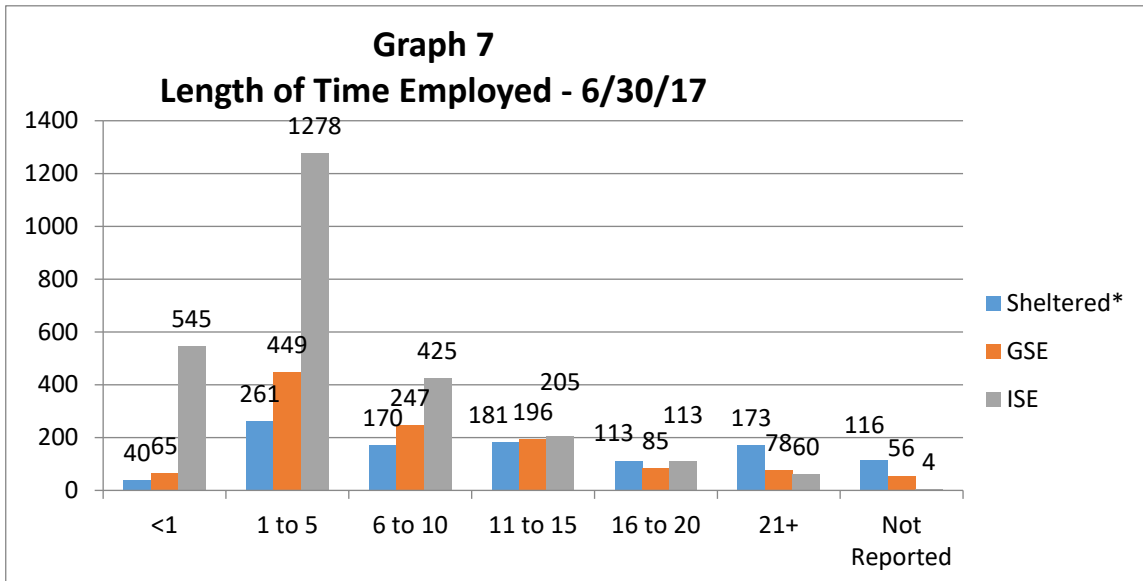


Average length of time at current job- these data are no longer specific to disability group, and, therefore, reviewers cannot compare the length of time individuals with ID versus DD maintain a job. The expectation is that 85% of individuals will hold their jobs for at least twelve months.

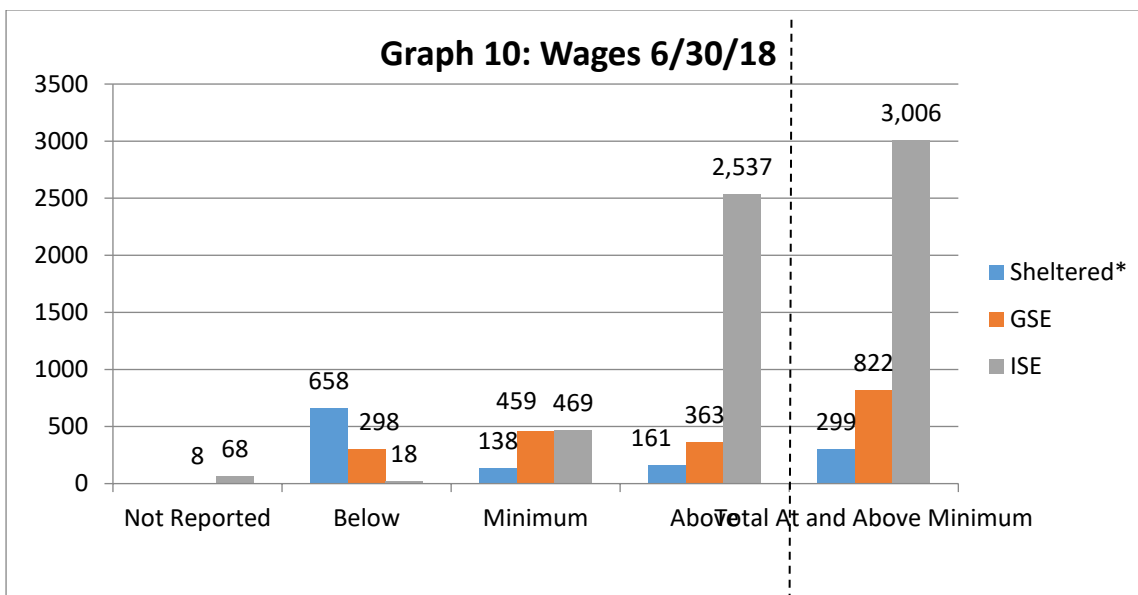
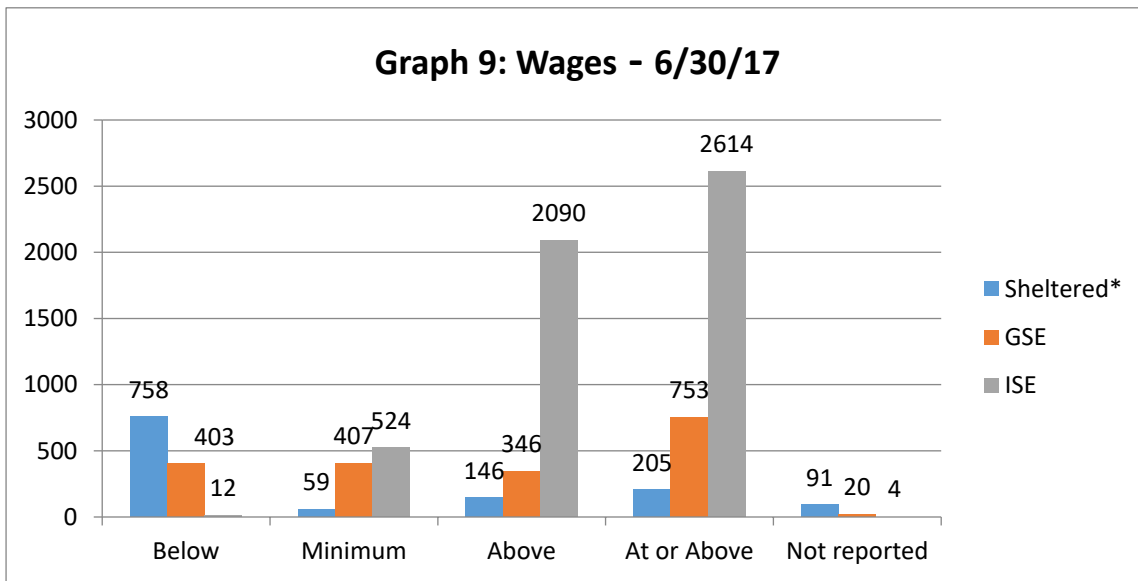
Overall, 81% of all individual employed worked at their job for one year or more. This is impacted because only 77% of individuals in ISE held their jobs for one year or more, compared to 92% of individuals in GSE. However, it is important to consider the increases in the number of individuals who have become ISE participants in the past year. The Settlement Agreement is not clear on this point. The Independent Reviewer has instructed the Expert Reviewer to not include the individuals newly hired, within the past twelve months, but only those employed at the beginning of the twelve-month period who had the opportunity to sustain employment for a full twelve months.

As has been noted previously in this report, the number of participants in ISE increased by 462 individuals. These individuals will have worked less than twelve months as of June 2018. Subtracting this number from the number of individuals in the workforce as of June 2018, there are a total of 3800 individuals who might have retained their jobs for more than twelve months. Subtracting these 462 individuals who have newly acquired employment in the past twelve months from those who have been employed for fewer than twelve months, and subtract them from the total number employed of 4262, then the percentage who have retained employment for more than twelve months represents 91% of the employed population who were employed twelve months ago and therefore had the opportunity to retain this employment. This is determined based on a total of 3806 individuals who were employed in June of 2017, and the fact that of these, 3461 have been employed for more than twelve months.

Graph 7 displays this information for June 2017 and Graph 8 displays the data for June 2018.



Earnings from supported employment DBHDS collected information regarding wages and earnings. The two graphs below depict the number of individuals that earn above or below minimum wage by employment program type for June 2017 (Graph 9) and June 2018 (Graph 10). All but eighteen individuals in ISE earn at least minimum wage as of June 2018 compared to seven earning less than minimum wage in June 2017. However, of the individuals in GSE, the percentage earning less than minimum wage has decreased from 40% in June 2017 to 26% in June 2018. It is impressive that, of individuals in ISE, 82% in June 2018 compared to 77% in June 2017 are paid more than minimum wage.



Conclusion and Recommendations: The DBHDS is meeting the expectations set forth in 7.b.i.B.1.a, b, c, d, and e. For the third consecutive review period, the data reflect information from 100% of all providers including the providers who offer HCBS waiver funded services and all employment related data from DARS relevant to the I/DD population.

It is very positive to continue to have data that include all individuals with ID and DD who are employed. The increase in individuals in ISE is noteworthy in the year between June 2017 and June 2018.

I repeat my previous recommendation that the Parties decide what if any outcomes are expected and required in the following areas: the amount of earnings; the number of individuals in pre-vocational services; and the length of time individuals are in pre-vocational services. Currently the Agreement does not specify measurable outcomes, but rather only requires that DBHDS report accurately on these data elements.

V. SETTING EMPLOYMENT TARGETS

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

DBHDS has set employment targets at two levels. A target was set on December 30, 2016 for 4,218 individuals to be employed, in both ISE and GSE, by June 30, 2019. This represents a target of 25% of the total number of individuals with I/DD between the ages of 18 and 64 years old who are either on the waivers or on the waiting list (16,871). As of June 2017, 3,806 of these individuals were so employed, representing 23% of the total number of 16,871. The accomplishment as of June 2018 when a total of 4262 individuals were employed through either GSE or ISE is even more impressive. This is 25% of the number of individuals who were on the waivers or waiver waiting lists as of December 2016. DBHDS has already met the target that it set to achieve by June 2019.

The second goal of the Commonwealth is to increase the number of individuals who are employed through waiver-funded programs. Although the number of individuals who are actually participating in HCBS employment services has increased, DBHDS's progress toward the achieving its targets for increasing employment for these individuals slowed during this reporting period. The targets depicted in *Table 1* are for the total number of individuals in ISE for each of the next five fiscal years. These goals were set by DBHDS and the SELN in March 2014.

End of FY	ISE	GSE	Total
16	211	597	808
17	301	631	932
<i>18</i>	<i>566</i>	<i>731</i>	<i>1297</i>
19	830	831	1661
20	1095	931	2026
<i>Total Increase '16-'20</i>	<i>884</i>	<i>334</i>	<i>1218</i>

Comparison of the Targets- As of June 2018, 972 individuals were participating in ISE and GSE waiver-funded services, an increase of 146 individuals since June 2017. Although, this increase represented an increase of 17.6%, it is 325 fewer individuals than the target of 1297 individuals that DBHDS had set to reach by the end of FY18. DBHDS has not met its target for employment participation in the waivers for FY18.

Individuals in Supported Employment-the Commonwealth's current goal is to reach 85% of the total number of individuals who are in ISE to remain employed for 12 or more months. As of June 2018, 91% of individuals remained employed who had been employed twelve months earlier.

The Commonwealth is reporting that more individuals with IDD are employed throughout the Commonwealth's employment programs, which achieves the Commonwealth's overall employment target. However, despite an increase of 117 individuals during Fiscal Year 2018, the Commonwealth has only achieved 74.9% (972) of its target for employment for 1,297 individuals with waiver-funded services. There has been a decline in the number of individuals in GSE of almost thirty individuals. It appears that the waiver redesign is supporting the employment goals as evidenced by the increase in the number of ISE participants. Stakeholders report satisfaction with much of the waiver redesign. Members of the E1AG anticipate the inclusion of transportation supports for employment related travel under the waiver will have a positive impact on increasing the number of waiver participants who become employed. DBHDS set ambitious goals for the end of FY18 for both ISE and GSE waiver participation. Since these goals were set in 2014, DBHDS has introduced community engagement, which is increasing significantly in participation. DBHDS reported that the agency and the E1AG plan to revisit these specific targets for employment for waiver participants in light of trends to date and the availability of other integrated meaningful community activities for individuals with I/DD who are waiver participants.

There is a table in the Semiannual Employment Report that captures the number of unique individuals who have had a service authorization for each day service in the waiver including ISE and GSE between September 2016 and September 2018. This graph is included in this report as *Graph 11: Total Number of Unique Individuals* and is more fully discussed later in this report regarding community engagement.

The number of individuals *authorized* for ISE and GSE differ from the number of individuals *participating* in ISE and GSE. In June 2017, 346 ISE and 674 GSE authorizations were awarded versus 305 ISE and 521 GSE actual participants. The number of authorizations versus the number of actual participants in 2018 follows a similar pattern: 458 ISE authorizations versus 422 participants, and 604 GSE authorizations versus 550 GSE participants. Both authorization numbers are higher than the number reported as actually receiving waiver ISE and GSE services.

In June 2018, 92% of the ISE authorizations appear to have been utilized, and 91% of the GSE authorizations were utilized. It appears that funding exists to support an increase in the number of individuals who have access to ISE and GSE waiver services. However it is of interest that the number of authorizations for ISE and GSE in June 2018 totals 1062. This is significantly below the target set for waiver employment of 1297 for the end of FY18, which is June 2018. It appears that the shortfall is due to a combination of Case Managers having not applied for authorization for employment services and ESOs not arranging for enough jobs to reach the DBHDS employment targets. DBHDS does reference this in the semi-annual report and recommends that the E1AG Data Committee follow-up on the significant decrease in GSE participation, in light of the high number of authorizations. DBHDS also notes that the decrease is related to provider restructuring that has happened to respond to new requirements of the Workforce Innovation and Opportunities Act (WIOA) and the CMS Home and Community Based Settings Rule. DBHDS also credits the advent of community engagement (CE) and some individuals and authorized representatives choosing CE rather than employment services.

CE was designed to provide inclusive community-based day activities, rather than group day support in congregated and segregated settings, as an option for individuals who were not ready or interested in employment and to enhance the lives of individuals with part-time employment. It was not intended to replace employment for individuals capable of and interested in working. These data will need further analysis in future reporting periods to determine if there are trends and unintended consequences on employment growth by offering this new service option.

In order for the Commonwealth to reach its employment targets in future fiscal years, especially in ISE for individuals in the HCBS waiver programs, the DBHDS will need to concentrate on increasing provider capacity. Its plan to provide training and technical assistance to providers to offer employment support to individuals with more significant disabilities should prove helpful to increase the number of waiver participants who are employed.

Conclusions and Recommendations: the Commonwealth has met the target it set for the percentage of individuals with IDD who would be employed by 2019 across all of the DARS and DBHDS waiver employment programs which responds to Section 7.b.i.B.2.a. The Commonwealth has also set targets to meaningfully increase the number of individuals receiving services through the waivers. These targets have not been achieved even though the number of individuals employed in the waiver program has increased between June 2017 and June 2018. The increase in the number of individuals employed in the waiver is encouraging and demonstrates more positive achievement than was previously observed. The Commonwealth has surpassed the expectation of retaining employment for at least twelve months. For individuals who were employed in June 2017, more than 85% remained employed as of June 2018.

I support the recommendations the DBHDS made in the Semiannual Employment Report draft. Continued efforts to fully implement these recommendations would further DBHDS's efforts to achieve its employment goals. Recommendations are below. Note that the bolded annotations that follow each recommendation are the DBHDS updates as of June 2018.

1. *DBHDS needs to continue collaborating with CSBs to ensure that accurate information about the different employment options is discussed with individuals in the target population and that these discussions are documented.*
 - a. *Work with the SELN to develop a video that shows the conversation between a case manager and individual and their family to show how to have a better conversation. (9/30/2017)*
(Completed)
2. *Increase the capacity of the Commonwealth's provider community to provide Individual Supported Employment services to persons with intellectual and developmental disabilities by providing technical assistance and training to existing and potential new providers.*
 - a. *Report the number of waiver providers offering Individual Supported Employment and Group Supported Employment. (6/2017)*
(Update: 39 ESO's offering ISE; 21 ESO's offering ISE and GSE; and 23 ESO's offer GSE only of the 66 ESO's in Virginia)
 - b. *Training for providers to support people with more significant disabilities. (6/30/2018)*
DBHDS reports this will be addressed in FY19
 - c. *Competency development: while projected for 6/30/2018 completion, DBHDS reports this is underway*

- d. Find out from ESO's additional services offered/sub contracted with to identify potential combination of services that would help providers be better able to support people with specialized needs (6/30/2018)
3. Increase capacity in parts of the Commonwealth that have less providers and employment options. Create a map of the service providers in each of the Regions and the services provided so we can track increase in capacity. **(Provider Survey complete)**
4. Continue to collaborate with DARS, Employment Service Organizations, and DMAS to collect and report on employment data. (Semi- Annually)
(Update: on schedule)
5. Do a comparison in future reports of employment discussions and employment goals to evaluate the impact on the percent of people employed per region. **(DBHDS reports the data is sufficiently consistent to initiate this review and has the staff resources to accomplish the task)**
 - a. DBHDS will follow up with the CSBs who have data reporting concerns around the discussion of employment and goals to address barriers to employment.
6. Create data tables around the waiver data according to old slots, new slots, and training center slots. (Not yet available, but undertaken by the EIAG)
7. Implement recommendations from the Regional Quality Councils. (6/30/2018)
 - a. Create success stories of employment that identify individuals according to the current support level as indicated by their supports intensity scores. **(Underway)**
 - b. Develop tools/training for individuals and families **(significant accomplishments in completing FAQs and guidance for families Listening sessions are being held throughout Virginia in the fall of 2018)**
 - c. Gather transportation data **(the new transportation waiver service is being piloted by five CSBs and will be available to employment waiver participants statewide beginning in January 2019)**
 - d. Improve communication with DOE around transition age youth and employment services and supports **(MOU issued)**
8. Monitor the number of transition age youth entering non-integrated work settings to determine potential future intervention. (Semiannually)
9. Develop additional detail regarding individuals who are earning subminimum wage by age and job type to determine if any trends exist. (6/2017) Use current data to establish baseline data and present to Advisory Group for refinement.
10. Develop a trend report based on the previous four semiannual reports for: unemployment rates; NCI data; individuals working fewer than ten hours per week; individuals retaining employment for less than five years; low wage earners earning tips; and the reasons for the decreases in GSE participation **(in process will be finalized using the June 2018 data)**

It would be helpful if at the end of each fiscal year DBHDS could analyze and report the impact of new waiver programs definitions and funding rates on increasing its waiver opportunities and achieving its targets for ISE and GSE. The new waiver slots are allocated to individuals based on the urgency of their need. Older individuals or youth with intense behavioral and medical challenges may need many of the available slots. Unlike many other states, none of these new slots are targeted for employment, particularly for individuals who graduate from or age-out of school eligibility. Achieving its annual employment targets will require a combination of individuals entering employment services. Some of these individuals will receive new and rollover wavier slots. Others will have had waiver slots and transition from receiving services in congregated and

segregated settings (i.e., sheltered workshops and group day support programs). These transitions will require re-education of families and case managers combined with more vigorous implementation of the Commonwealth's Employment First Policy. For example, although the Agreement requires that employment goals be developed and discussed annually, the Independent Reviewer's Individual Services Review studies continue to find that case managers rarely develop potential goals to help explain to individuals and authorized representatives the practicable paths that are available to successful employment. Although, the Independent Reviewer has repeatedly reported this non-compliance, the Commonwealth has not included promoting this required practice in its plan to achieve its targets or in its training of Case managers. In addition, the General Assembly has recently passed legislation supporting continued funding of sheltered work and pre-vocational programs in response to lobbying efforts. This may negatively impact the Commonwealth's efforts to transition individuals from these large congregate settings to community-based employment opportunities.

I continue to recommend that the Commonwealth further refine these targets by indicating the number of individuals for whom it hopes to provide ISE from the following groups: individuals currently participating in GSE or pre-vocational programs; individuals in the target population who are leaving the Training Centers; and individuals newly enrolled in the waivers during the implementation of the Settlement Agreement. I am pleased that the E1AG has also made this recommendation, however the Commonwealth has not yet undertaken this analysis.

Creating these sub-groups with specific goals for increased employment for each will assist DBHDS to set measurable and achievable goals within the overall target and make the undertaking more manageable and strategic. Realistic and successful marketing and training approaches to target these specific groups can be developed through discussions between the DBHDS and the E1AG. A collaborative outreach effort to families, case managers, CSBs, Training Center staff, and ESOs will assist the DBHDS to achieve its overall targets in each of the next three fiscal years. It is very positive that DBHDS and the E1AG plan to develop and offer training to providers to enhance their competencies to assist individuals with more severe disabilities to work.

VI. The Plan for Increasing Opportunities for Integrated Day Activities

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

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

Since the Commonwealth of Virginia entered into the Settlement Agreement with the US DOJ, DBHDS focused its work and activities on increasing employment opportunities for individuals with ID and DD. The Independent Reviewer directed DBHDS to develop a plan by March 31, 2014 to describe its approach to create integrated day activity capacity throughout its provider community and to ensure that individuals in the target population can participate in these integrated activities as the foundation of their day programs. During this review period, DBHDS submitted

the revised Community Engagement Plan FY2016-FY2018, which includes updates through FY18Q4. The foundation for community engagement is included in the HCBS waiver as redesigned to offer community engagement, community coaching, and related services with new or revised funding rates.

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

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

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

The DBHDS Community Engagement Plan, as revised December 29, 2015, was updated to reflect the status of achieving the six goals as of June 30, 2018.

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

Status- DBHDS has created the CEAG with broad stakeholder membership. All of the CEAG's original planned actions have been completed. During this review period DBHDS and DARS trained 235 providers and case managers in documentation requirements. DBHDS provided family-based training to an additional fifty families and individuals. Technical assistance was provided individually to providers who requested it by DBHDS. DBHDS reports that this goal has been fully achieved.

2. Policies are in place to promote and encourage CE Activities.

Status- The CEAG developed new material about CE for the Provider Manual and made recommendations for additional provider training.

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

Status- Technical assistance continues to be provided to CE providers to help meet waiver expectations by DBHDS. A Provider Issues Resolution Workgroup was created by the CEAG. The workgroup developed a provider survey, which was recommended by the CEAG, to identify both challenges and successes that may inform future planning by DBHDS. One result is that DBHDS is establishing a HCBS Business Acumen Business Development Learning Collaborative.

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

Status- The RFP awardees continue to meet to discuss successes and challenges. These providers' experiences are being used as examples for the Best Practice Manual and for fact sheets for providers. The CE RFP group met for its final time in June 2018, as its work is complete.

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

Status- There are currently 198 licensed provider locations of community engagement (non-center based day) services, an increase of fifteen since the previous reporting period. There are 2,375 approved authorizations for individuals to receive CE, compared to 1,588 in June 2017; and there are 239 approved authorizations for Community Coaching (CC) compared to 120 in June 2017. CE authorizations have increased by 787. These data are as of June 2018. This is an increase in CE participation of 50% and of 99% in CC. (see Graph 11 on page 25).

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

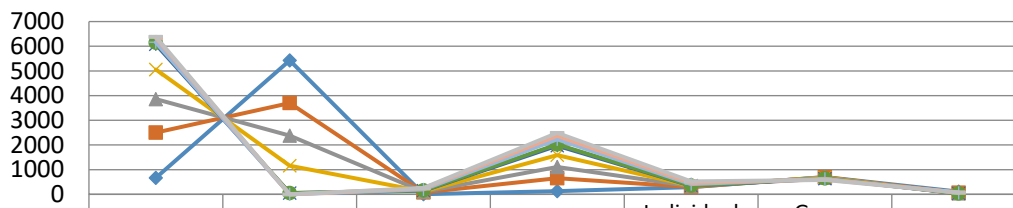
Status - DBHDS and the CEAG are reviewing providers' practices on collecting data and plan to use National Core Indicator (NCI) and Quality Service Review (QSR) data. Providers completed a self-assessment and DBHDS, in collaboration with DMAS, reviewed and have followed up to provide greater guidance to providers who did not demonstrate compliance with agency expectations. No results or specific data were shared.

The guidance from DBHDS and DMAS becomes even more important as the participation in CE and CC increases substantially over a short period of time. DBHDS needs data that provide information on the hours of involvement and the type of activities offered. During a period of rapid program growth, it is especially important that the DBHDS can monitor the effectiveness of this program and the satisfaction of its participants. Its process with DMAS may achieve this goal, but this cannot be ascertained without data to analyze.

Individuals Participating in Day Service Options

DBHDS has provided data, which is depicted in Graph 11 below that allows for comparison and growth of authorizations for CE and CC from 9/30/16 through 9/30/18. This information reflects the number of individuals authorized for each service type.

Graph 11
Total # of Unique Individuals - 6/30/18



	Group Day 97150	Group Day 97537	Community Coaching 97532; 97127	Community Engagement T2021	Individual Supported Employment H2023	Group Supported Employment H2024	Workplace Assistance H2025
9/30/2016	668	5427	7	130	295	701	108
12/31/2016	2504	3698	79	658	300	695	63
3/31/2017	3859	2378	106	1109	328	684	41
6/30/2017	5059	1160	120	1588	346	674	34
9/30/2017	6077	53	150	1969	353	638	40
12/31/2017	6145	53	162	2020	356	647	40
3/31/2018	6161	2	203	2230	413	627	60
6/30/2018	6339	0	239	2375	458	604	70
9/30/2018	6383	0	261	2491	526	585	77

***DBHDS reports:** “It should be noted workplace assistance shares the previous pre-vocational code and some of the authorization had not been ended until the current quarter. Workplace Assistance will be monitored starting the fourth quarter and going forward for utilization.”*

In the twelve-month period, 9/30/17 and 9/30/18, there was an increase of 111 individuals authorized for Community Coaching (CC). The authorization for individuals in Community Engagement (CE) grew dramatically in this twelve-month period from 1969 to a total of 2491, or 26%. There was an increase of 253 individuals in Group Day in the same period. However, this is only a 4% increase in the number of individuals authorized for group day. This may indicate greater preference for and choice of day supports that are more focused on employment or community engagement options.

Authorization for Group Supported Employment (GSE) reduced by fifty-three individuals between September 2017 and September 2018. There was an increase in authorization for Workplace Assistance of thirty-seven individuals. Workplace assistance no longer includes pre-vocational services as of June 2017.

These employment and day support programs had 10,323 individuals authorized as of 9/30/18 compared to 9,280 as of 9/30/17. The percentage of individuals authorized for CC, CS and ISE increased from 27% in September 2017 to 32% of the individuals authorized for some type of day support service. This results primarily from the steady increase in the number in CE and significant increase in the number of individuals in ISE resulting in a percentage increase of 26% in CE and 49% in ISE.

Conclusion and Recommendations: The DBHDS and the CEAG have developed a robust definition of Integrated Day Activities, which is now called Community Engagement. These services have been approved by CMS and offered to waiver participants since September 2016. There are a total of 10,323 individuals authorized for waiver day services including center-based day services. As of 9/30/18, 2752 (27 %) of these individuals are authorized for CE and community coaching. This is a significant increase and illustrates a strong interest among individuals and families. It is clear from the number of providers that have become licensed for these services that the provider community is responding to the direction set by DBHDS to transition its system of day supports away from segregated center-based programs to services that support individuals with IDD in inclusive community opportunities.

DBHDS expects to produce quarterly reports summarizing demographic data, successes, barriers and the average hours of participation in CE and community coaching by urban and rural areas. I recommend that DBHDS initiate this during the next reporting period so there are specific data to better determine the success of this initiative longitudinally.

DBHDS and the CEAG have continued to do considerable work during this reporting period including significant training and information distribution. During this review period DBHDS continued to increase the availability of community engagement services for hundreds of individuals. It will be helpful for the Commonwealth to establish baseline data, to develop targets, to articulate its expectations for hours of participation, and to determine how it will monitor the provision of these services to assure they are meaningful for the individuals.

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

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

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

Virginia has maintained its membership in the SELN and issued a policy on Employment First. Anita Mundy continues as the Employment Services Coordinator.

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

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

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

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

Development of Employment Goals and Employment Discussions

As mentioned previously, the Independent Reviewer’s Individual Services Review study has found that Case Managers rarely develop goals for its discussions with individuals and, where applicable, their authorized representatives. The development of goals, which is a specific requirement by the Agreement, are very helpful in educating individuals and their Authorized Representatives about the practicable paths to group and individual supported employment. This is especially true for individuals who have not had any, or have not had a positive, work history, and those with challenging behaviors and medical needs. The development of potential goals is very helpful to illustrate the potential paths to employment and to prompt discussion and to resolve misunderstandings of the impact of supported employment on benefits and the new approaches to transportation. This review did not find that the Commonwealth has included plans, or taken any other actions, to ensure implementation of the required annual development of employment goals.

DBHDS reports that a total of 7,612 adults’ case managers conducted annual ISP meetings or updates in this reporting period. However, 11,252 individuals between the ages of 18-64 receive case management, most of whom should have annual ISP meetings. CSBs report that ISP meetings were conducted for 68% of the total number of individuals who should have had an ISP meeting. DBHDS believes this is an issue of data inaccuracy rather than an indication that CSBs are not convening teams annually for many individuals’ ISP meetings. Of these 7,612 individuals, their case managers checked a box that indicated that a total of 7,008 individuals had discussed integrated, community-based employment during their annual ISP meetings. This indicates that 92% of the individuals who had an ISP meeting conducted discussed employment at some level. However when you compare the number of individuals who had a conversation about employment to the total number who have case managers, and should have had an ISP meeting held, the percentage decreases to 62%.

Six (15%) of the CSBs reported that case managers had employment discussions with all of their waiver participants, compared with five (12.5%) of CSBs reported to have achieved 100% as of June 2017. The number of CSBs reporting these employment conversations with at least 90% of individuals increased from twenty-five to thirty-three, for a total of 82% of all CSBs. Of the twenty-seven in the 90-99% category, six of the CSBs reported that case managers had such discussions with 99% of the individuals.

It is important to look at the data specific to each of the 40 CSBs. The following table, *Table 2*, provides a breakdown of the percentage of individuals by CSB who were engaged in an employment discussion.

Number of CSBs June 2017	Number of CSBs June 2018	% of Employment Discussion
5	6	100%
20	27	90-99%
5	3	80-89%
2	1	70-79%
0	1	60-69%
2	0	50-59%
1	0	40-49%
2	0	30-39%
1	2	20-29%
0	0	10-19%
2		0%

A total of 2,879 of the 7,008 individuals in June of 2018 compared to 2,212 of the 6,945 individuals in June 2017, have employment or employment related goals in their ISP. This results in a statewide average of 38% of individuals who had an annual ISP review in this reporting period who have an employment or an employment-related goal in their ISP. This compares to 32% in June 2017. Twenty-one CSBs in June 2018, compared to thirteen CSBs in June 2017, reported that they met the DBHDS expectation to have employment goals included in ISPs for at least 35% of their consumers. Two CSBs did not report employment goals for any waiver participants and another two reported employment goals for 15% or less. Eight CSBs included employment goals for at least 50% of waiver individuals and one CSB, Horizon, set goals for 100% of the individuals for whom they convened the ISP meeting.

The twenty-six CSBs that reported having discussed employment with 95% or more of individuals having ISP meetings are: Alexandria, Alleghany, Arlington, Blue Ridge, Chesapeake, Chesterfield, Colonial, Crossroads, Cumberland Mountain, Eastern Shore, Fairfax-Falls Church, Goochland-Powhatan, Hampton-Newport News, Hanover, Harrisonburg-Rockingham, Henrico, Highlands, Horizon, Mount Rogers, Norfolk, Northwestern, Piedmont, Rappahannock, Rappahannock-Rapidan, Southside and Virginia Beach. This number increased from twenty CSBs that discussed with at least 95% of their participants in June 2017.

Twenty-one CSBs included employment goals for at least 35% of the individuals who had ISP meetings, which is an increase of eight CSBs when compared to June 2018. These are: Alexandria, Alleghany Highlands, Arlington, Chesterfield, Colonial, District 19, Goochland-Powhatan, Hanover, Harrisonburg-Rockingham, Henrico, Horizon, Loudoun County, New River Valley, Northwestern, Prince Williams County, Rappahannock, Rappahannock-Rapidan, Rockbridge,

Southside, Virginia Beach, and Western Tidewater. The full DBHDS report of the CSB effort to meet these two target goals is detailed in Attachment 1.

The issue of the number of CSBs that have not had employment conversation with all of its adults with ISPs is of concern to the statewide Quality Improvement Council and has been minimally discussed by some of the Regional Quality Councils, and has not been discussed by the E1AG. The DBHDS efforts to date are still focused on improving the accuracy of the reporting of data, but not on how to monitor that the employment discussions occur and employment goals are established and included in individuals' support plans.

DBHDS continues to report that it has worked with the Case Management Coordinator and Performance Contracting staff to retrain all CSB case managers on these data elements. The E1AG and DBHDS have worked together to develop both written materials and a video for case managers to build their competencies to conduct employment discussions and develop meaningful employment goals for individuals. DBHDS also developed materials and FAQ's for families. DBHDS reports that they can more readily have agency quality monitoring and enhancement staff review a sample of ISPs to determine the meaningfulness of the employment conversations and the suitability of the employment goals now that data entry are more reliable and consistent. The E1AG has also recommended that DBHDS review employment outcomes for individuals compared to the employment discussions and goal setting to determine if the opportunities for employment are increased as a result of more in-depth employment discussions and including measurable employment goals in ISPs.

The Commonwealth reports that it has improved its performance regarding its target of having employment discussions, which it achieved for 92% of those individuals who had an ISP meeting convened in the year ending June 2018. In this same time period DBHDS reports that it surpassed its target of having employment goals included in at least 35% of the ISPs, by achieving this for 38% of the individuals who had ISPs developed or revised between June 2017 and June 2018. However, in determining compliance with *III.C.7.b* the fact that ISPs were only convened, or reported on for 68% of those who should have had these ISP meetings convened must be considered. There is also considerable range in the individual levels of compliance across the forty CSBs. The range in the number of annual ISPs convened ranges from 1-96%. The range of employment discussions held ranges from 27-100%; and the range of ISPs that include employment goals ranges from 0-100%. The Commonwealth has demonstrated improvement in its effective and sustained implementation of its Employment First policy by the CSBs. However, it has still not demonstrated that it has the ability through its performance contract to require CSBs to take effective corrective actions that address and resolve repeated performance below acceptable standards.

The Engagement of the SELN - The VA SELN Advisory Group was established to assist DBHDS to develop its strategic employment plan, to set the targets for the number of individuals in the target population who will be employed, and to provide ongoing assistance to implement the plan and the Employment First Policy. The SELN Advisory Group was renamed the Employment First Advisory Group. Its members are appointed for two-year terms. The E1AG has twenty-six members. It includes self-advocates, family members, advocacy organization representatives, CSB staff, educators, employment providers, and representatives of the following state agencies: DBHDS, DMAS, DARS, and VDOE. This Advisory Group has several sub-committees: membership, training and education, policy, data, and interagency collaboration. I reviewed the

E1AG meeting minutes for all meetings that occurred during the review year. The meetings are well attended. DBHDS and members report that the membership of the group will be expanded in January 2019 to include individuals who represent the needs of individuals served by DBHDS who have mental health challenges and other disabilities to ensure all disability groups are included in the mission of the Advisory Group.

DBHDS has formalized the work of the Community Engagement Advisory Group (CEAG). It has a membership of twenty-three individuals, which includes representatives of all of the stakeholder groups. Members have also been appointed for two-year terms. Two sub-committees, policy and training, continue to operate. DBHDS provided minutes from the meetings held during the review period, the last of which was June 22, 2018. The CEAG continues to review and have input into the Best Practice Manual and to review provider concerns that effect implementation of CE. The CEAG has addressed service definitional issues and training. This Advisory Group will be disbanded since its mission has been fulfilled and its objectives have been met.

The E1AG remains active in its advisory capacity to DBHDS regarding its employment initiatives. I interviewed four members of the E1AG for this reporting period to gain perspective on the work of the advisory group and the progress the Commonwealth is making to meet the Settlement Agreement requirements for employment.

1. *The operation of the SELN and the opportunity afforded its members to have input into the planning process* -all members who I interviewed continue to report that the E1AG is active and has a diverse and effective membership. Members report that they have opportunity for meaningful input. They appreciate the structure of the sub-committees for policy, training and data. They report that the sub-committees function effectively. The structure is for the full E1AG to meet bimonthly and for both sub-committees to meet during alternate months. This continues to assure effective planning and appropriate follow through. Members are pleased that decisions are more data driven and that the input of the E1AG is considered meaningful and seriously used by DBHDS as it implements its employment initiatives. The changes in membership have led to a very cohesive, productive advisory group as members attend more regularly and are able to stay abreast of the data and implementation results of various strategies to improve data reporting and the achievement of employment goals.

2. *Review of the Employment Targets*- Members appreciate the continued progress to increase the number of individuals overall who are employed, both overall and in the waiver programs, while acknowledging that the waiver targets are not being met. The June 2018 Semiannual Employment Report had not been shared with the E1AG as of the interviews for this report, but the employment report was planned to be shared at the October 17, 2018 E1AG meeting. The comments members made were based on the December 2017 employment report. Members are encouraged that transportation will be a full-fledged waiver service for employment (non-medical) transport effective January 2019. The members compliment DBHDS' decision to pilot this service option with 4-5 providers this fall to help address any unforeseen barriers and to develop some experience with billing for the service.

3. ***Review of CSB Targets-*** Members think that case managers will benefit from continued training on employment to fully embrace the principles, intent, and the policy direction; and to understand their role in the ISP planning to assist families and individuals to seriously consider employment as the first and priority option. The E1AG has been involved with DBHDS to develop training material for the CSB case managers which include employment scripts, answers to frequently asked questions, and employment discussion videos. Members report that the training efforts of DBHDS, including the production of videos, are focused and positive. There is some concern about the workload of case managers and whether they can fully devote themselves to facilitating meaningful employment discussions and work toward achieving measurable goals.

4. ***Provider Capacity and Training-*** Members are encouraged that more individuals are employed and there is better response from ESOs who provide employment as a waiver service. They support the plan to develop training to assist employment providers assist individuals with more significant disabilities to become meaningfully employed. The Commonwealth's participation as a state in the Business Acumen Learning Collaborative may help achieve better provider capacity and ability to sustain employment supports for this population.

5. ***Review of the RQC Recommendations-*** The recommendations of the RQCs are shared with the E1AG and are now always summarized in the Semiannual Employment Reports. These include creating vignettes of employment that demonstrates its viability for individuals with different levels of ability; developing tools and training for individuals and families and evaluating its effectiveness; gathering transportation data; and improving communication with DOE regarding youth who are transitioning.

6. ***Interagency Initiatives-*** the members of the E1AG who I interviewed were positive about the interagency cooperation between DBHDS and DARS that resulted in a new Memorandum of Agreement (MOA) that was issued this past summer. It allows waiver providers to provide employment support to waiver participants directly at any time that DARS is under its order of selection. An order of selection places a hold on authorizing DARS support for new applicants and in reality creates a waiting list for these vocational supports. E1AG members believe this will be incredibly helpful to increase employment for individuals with I/DD.

7. ***Transportation-*** Members fully support adding non-medical transportation as a waiver service and see it as addressing a critical barrier for many individuals to be able to work. DBHDS' willingness to pilot this enhancement before implementing it as a waiver service was viewed as a positive effort.

Conclusion and Recommendation: The DBHDS continues to meet the Settlement Agreement requirements to maintain the SELN, has set goals for the CSBs in the performance contracts, and has a full time Employment Services Coordinator, but has not fully met the provisions of *III.C.7.b*. The CSBs have not consistently offered employment as the first and priority option or developed and discussed employment service goals annually, a target that was anticipated to be achieved by June 2015.

VIII. Regional Quality Councils

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

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

Quality Improvement Meetings

There is statewide DBHDS Quality Improvement Council. It convened in all four quarters of the review year. There were not employment discussions at all meetings but employment was on the agenda for two of the quarterly meetings. The QIC reviewed recommendations from the RQCs and also reviewed employment data from the NCI surveys completed in Virginia. During one meeting the members discussed the employment targets after a presentation by DBHDS.

RQC Regional Meetings

The minutes for the Regional Quality Councils (RQC) were reviewed for all five Councils. These meetings occurred for each RQC in FY18Q2, FY18Q3, FY18Q4 and FY19 Q1. Region IV's RQC meeting was cancelled in September 2019 because of Hurricane Florence. Heather Norton or Anita Mundy discussed employment targets with each RQC, highlighting the data in both the semiannual reports of December 2017 and June 2018.

DBHDS staff provided updates on employment for each Council meeting. During FY18Q2 and FY18Q3 some of the Councils had more in-depth discussions and made recommendations. These focused on training for CMs; clarification of reporting expectations; addressing the employment needs of individuals with more significant disabilities; the need for transportation; and the need to address the needs of this population when DARS is under an order of selection. These recommendations and concerns were all shared with the E1AG in timely fashion. Many of these recommendations were implemented by E1AG and DBHDS.

The RQCs' meeting minutes reflect that DBHDS consistently made presentations about employment.

None of committees had all of their members attend until FY18Q4 when some of the RQCs reduced their memberships. Many of the RQC meetings were held without an employment service representative or a family representative. Each of the RQCs discussed the problems with consistent attendance at one or more meetings during the reporting period.

The Commonwealth is responding to the requirement of involving the RQCs because the meetings were held and employment was at least presented. Targets are expected to be reviewed on an annual basis and were reviewed semiannually. I continue to recommend that the DBHDS converse with the regional committees to determine the reasons for the lack of engagement of individuals, families and employment providers in committee meetings. Their attendance is important to

ensure local and regional concerns and recommendations for quality improvement are being brought to the attention of the state.

Conclusions and Recommendations: DBHDS meets the provisions of III.C.7.d because the employment target for sustaining employment for twelve months was reviewed by the five RQCs in the reporting period. DBHDS meets the provisions of III.C.7.c because there were quarterly reviews of employment data. All five regions held meetings in all four quarters, with the exception of the cancellation of RIV due to the hurricane. However, not all RQCs have meaningful discussions. I continue to recommend the role of the RQCs to review employment data be changed to semiannually to align with the availability of the Semiannual Employment Report and that each RQC make recommendations for consideration by the E1AG so all parts of the state have the opportunity for input that may lead to policy change.

IX. SUMMARY

DBHDS has made significant gains during this reporting period in its increases in employment and in its efforts to implement community engagement. Its progress towards achieving its multi-year employment targets is mixed. DBHDS has improved its plan to create integrated day activities and participation in community engagement has increased significantly. The Commonwealth has increased the number of individuals who are employed. While this is more significant in DARS-funded programs, DBHDS should be recognized for increasing employment opportunities to an additional three hundred individuals during FY18. Overall there has been a significant increase in both employment and participation in community engagement activities.

The Commonwealth achieved its overall employment target set for FY19, and for the first time achieved one of the two targets set for the CSBs, to have employment goals for at least 35% of individuals who have ISPs completed in the review period. The CSBs have done better facilitating employment conversations with waiver participants but have not achieved this target of 100%. The overall progress, especially in community engagement and the sustained efforts to work collaboratively with stakeholders is noteworthy.

Attachment 1

CSB Performance Summary

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

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

Tracking Employment First Conversations:

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

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

The results of the data collection are presented below for the entire fiscal year of FY18 (7/1/17-6/30/2018).

Report #4 Employment (All columns ages 18 through 64 only) 7/1/17 - 6/30/18 Report Date: 08/25/2018	Receiving DD CM	Annual F2F Meeting	%	Employment Discussion at Annual ISP Meeting (Age 18-64) Data Element 91	Employment Goals in ISP Data Element 92		
				Total Discussions	%	Employment Outcomes	%
Chesterfield	831	564	68%	535	95%	267	47%
Crossroads	175	2	1%	2	100%		0%
District 19	293	129	44%	113	88%	49	38%
Goochland- Powhatan	60	42	70%	42	100%	20	48%
Hanover	171	98	57%	97	99%	51	52%
Henrico Area	509	320	63%	315	98%	142	44%
Richmond	413	350	85%	260	74%	111	32%
Southside	191	166	87%	164	99%	82	49%
Central Region	2593	1669	64%	1527	91%	721	43%
Chesapeake	255	107	42%	104	97%	31	29%
Colonial	141	101	72%	99	98%	42	42%
Eastern Shore	111	95	86%	95	100%	20	21%
Hampton- Newport News	443	265	60%	262	99%	61	23%
Middle Peninsula- Northern Neck	177	125	71%	117	94%	34	27%
Norfolk	435	319	73%	317	99%	105	33%
Portsmouth	205	182	89%	152	84%	59	32%
Virginia Beach	671	588	88%	583	99%	237	40%
Western Tidewater	236	163	69%	146	90%	59	36%

Eastern Region	2665	1945	73%	1875	96%	648	33%
Alexandria	86	56	65%	55	98%	39	70%
Arlington	129	104	81%	99	95%	38	37%
Fairfax-Falls Church	938	759	81%	742	98%	250	33%
Loudoun County	214	173	81%	159	92%	90	52%
Northwestern	329	244	74%	232	95%	86	35%
Prince William	379	145	38%	134	92%	93	64%
Rappahannock Area	499	245	49%	243	99%	215	88%
Rappahannock- Rapidan	221	157	71%	153	97%	70	45%
Northern Region	2775	1881	68%	1815	96%	880	47%
Blue Ridge	384	267	70%	257	96%	69	26%
Cumberland Mountain	156	124	79%	121	98%	32	26%
Danville- Pittsylvania	300	237	79%	190	80%	45	19%
Dickenson	21	11	52%	3	27%	1	9%
Highlands	126	68	54%	66	97%	19	28%
Mount Rogers	274	240	88%	236	98%		0%
New River Valley	255	198	78%	130	66%	132	67%
Piedmont	258	205	79%	204	100%	43	21%
Planning District I	172	85	49%	77	91%	8	9%
Southwestern Region	1926	1435	75%	1284	89%	349	24%
Alleghany- Highlands	53	51	96%	51	100%	20	39%
Harrisonburg- Rockingham	178	104	58%	103	99%	74	71%
Horizon	522	29	6%	29	100%	29	100 %
Rockbridge Area	48	38	79%	33	87%	18	47%
Valley	262	200	76%	54	27%	60	30%
Western Region	1379	686	50%	510	74%	282	41%
Statewide Total	11252	7612	68%	7008	92%	2879	38%

APPENDIX E.
REGIONAL SUPPORT TEAMS
BY: Ric Zaharia, Ph.D.



Consortium on Innovative Practices

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

Regional Support Teams
Requirements of the Settlement Agreement

By

Ric Zaharia, Ph.D.

November 1, 2018

Executive Summary

The Independent Reviewer for the *US v Commonwealth of Virginia* Settlement Agreement (SA) requested a follow-up review of the Regional Support Team (RST) requirements of the Agreement.

The themes in the Settlement Agreement that guide Regional Support Teams include:

- a) diverting individuals to the most integrated settings,
- b) identifying and resolving barriers to placement in the most integrated setting, and
- c) ongoing improvements in planning and development of community-based services.

During this past summer the Division of Developmental Services (DDS) implemented multiple changes to the RST process. The use of shorter electronic referral and choice forms and of more dropdown boxes should reduce case managers/support coordinators time and effort in having to draft narrative. Additional centralization of the process should also increase CSB (Community Service Board) accountability. Case managers/support coordinators and other CSB staff were involved in the revisions to the RST referral process.

This study found that the problem of late referrals (after or concurrent with an individual's move) has continued to improve with the recent changes in process. The RSTs reviewed for this study were again not always able to divert individuals from placement in group homes 5-persons or larger (GH5), nursing facilities (NF) or intermediate care facilities (ICF/IDD), but they are more consistently receiving referrals for these individuals with adequate time to identify and address barriers in needed services for individuals in their home communities.

During this past year, DBHDS has also generated a statewide approach to addressing service gaps and new slot development, which includes geo-mapping and self-calculating data displays. It makes data and startup funding available by region to private sector providers willing to grow the system's services. The startup funding, called Jump-Start Funding, is one-time monies designed to encourage collaboration among providers and to stimulate the growth of needed services and supports by illustrating to providers where growth opportunities and gaps exist. Currently the geo-mapping opportunities fully include new, integrated services and supports needed statewide. System gaps data for services and supports is expected to be incorporated later in the year. The overall strategy, the geo-mapping tools down to region, county, or city and the Jump Start funding, have been competently designed and, when the results are assessed, may represent a best practice strategy.

In addition, DBHDS has made available NASUAD's (National Association of States United for Aging and Disabilities) *HCBS Business Acumen Center* technical assistance to agencies desiring to expand services but wanting improved skill sets in financial competency, in business operations, and in process improvements. To date 29 agencies interested in growing their lines of business have been participating in this program.

Although the DDS has addressed the development of needed services and supports, Community Resource Consultant (CRC) functioning is still missing the formalized dimension of involvement in 'ongoing planning and development of community-based services'.

Methodology

- Reviewed RST Quarterly Reports: Q3, Q4 - FY18; Q1-FY19;
- Reviewed *RST Quality Improvement Recommendations*, Oct. 2017- Sept. 2018;
- Participated in webinar with DSD Provider Development Section (9.12.18);
- Reviewed *RST QIC-Update Report*, Sept. 2018;
- Reviewed Jump-Start Funding policies and formats;
- Reviewed DDS *Provider Data Summary*, Nov. 2017, June 2018;
- Reviewed completed VIDESs July - Sept. 2018, Regions II&IV;
- Reviewed children's PASRR Oct. 2017-Sept. 2018, Regions II&IV;
- Reviewed RST minutes from Regions II & IV for the period Oct. 2017 - Sept. 2018;
- Reviewed RST referrals from Regions II & IV for the period Oct. 2017 - Sept. 2018;
- Interviewed DBHDS leadership responsible for RSTs.

Findings

During this past summer the Division of Developmental Services Division (DDS) implemented changes to the RST process that included generating a new *Virginia Informed Choice* (VIC) form (reduced to one page with more dropdown boxes), issuing new guidance, revising the RST *Referral* form (reduced to one page with more dropdown boxes), developing a *RST Recommendations Tracker*, and further centralizing the process at DBHDS. The use of more dropdown boxes should reduce case managers/support coordinators time in drafting narratives, which may have been a disincentive to timely referrals. This past summer stakeholders were oriented to the new formats and processes through webinars and case managers/support coordinators were oriented through regional meetings. Case managers/support coordinators and other CSB staff were involved in the revisions to the RST referral process, which should optimize the likelihood of CSB adherence to the revised processes.

The lack of timely referrals by case managers/support coordinators, and therefore timely reviews by the RST, were problems that have been identified in each of our previous reviews. This study's review of Region 2 and 4 referrals for the pre-revision period indicated a late referral rate of 40% (38 late/95 referrals). For the subsequent period, June-Sept. 2018, the late referral rate for these two regions dropped to 12% (9/76). It is notable that DBHDS reports for all of FY 18 that RST statewide data showed an average late rate across the state of 21%. However, DBHDS's statewide RST data for the first quarter of FY19 showed a 35% (29/84) late referral rate. With two Regions achieving a 12% late rate, the remaining Regions apparently experienced late rates of up to 50%.

Although the Commonwealth committed in the Agreement to have all referrals to GH5s reviewed by the RST, DBHDS has established a goal of reducing late referrals to 20% or less by March 2019. Achieving even a generous rate of 20% of referrals failing to be submitted with adequate time for the RSTs to fulfill their responsibilities should be accomplished but will still require the monitoring of variances from this benchmark across CSBs and Regions. For example, after removing five (5) individuals who moved from one GH5 to another within an agency in Region 2, the remaining nine (9) late referrals were all for placement in GH5s.

One of the changes to the referral form includes an explanation for late referrals. This requirement should help DBHDS impact reductions in the late rates by clarifying why RST referrals are delayed. For example, the latest statewide data for Q1 FY19 suggests that half the late submissions (18) were due to case managers/support coordinators “forgetting” to submit referrals. Since Fiscal Year 2013, it has appeared that some CSBs have frequently ignored the requirement to submit referrals to GH5s to the RSTs. Because it appears that there are no consequences to CSB’s for not fulfilling the Commonwealth’s directive to submit such referrals, further clarifying might be worthwhile in order to identify workload “forgetting” versus intentionally “forgetting” (i.e. not bothering).

Of all the RST referrals for the June-Sept. 2018 period for Region 2 and 4, 50% of the referrals (38/76) were for GH5s. Of these 38 GH5 referrals, five (5) were individuals who moved from one GH5 to another within an agency, seven (7) were actually placed in group homes four or smaller, and 22 (67%) could be crosschecked and confirmed with WaMS service authorization print outs, which indicates the potential for utilization of WaMS to manage the late or non-referral problem. Four (4) GH5s service authorizations in WaMS for this period had no RST referrals on record, so DBHDS used this analysis to follow-up with the appropriate CSBs.

Although these data are encouraging, continued monitoring of CSBs “forgetting” to provide early notice of referrals is warranted. Hopefully, the late referral problem diminishes under the newly designed process and narrows down to a few individual case managers or supervisors whose non-compliant performance can be addressed and resolved.

For the June - Sept. 2018 period in Region 2 and 4, eight (8) cases were reviewed where placement in an ICF/IDD (6 individuals) or NF (2 adults) was considered. VIDES data on level of care determinations at admission confirmed the admission of these six (6) to ICF/IDDs. PASRR data reports were available to crosscheck only the referral of children, but the PASRR process is used in lieu of referral to RST per the Independent Reviewer. These results indicate the potential for utilization of the VIDES (Virginia Individual Developmental Disabilities Eligibility Survey) data to verify RST referrals.

Based on previous reviews, supporting emergency or crisis placements had become a core function of RSTs. For the six-month period July-December, 2016, more than half the situations reviewed appeared to be emergencies or crises (homeless, in jail, etc.). However, for the last six months of FY18, RST data indicated that emergencies had dropped to 12% (12/100) among all referrals. For the first quarter of FY19, 8% (6/75) of statewide RST referrals were reported as emergencies. In this review of the June-Sept. 2018 period in Region 2 and 4, 14% (11/76) of the cases reviewed were assessed as individuals in emergency circumstances. Parenthetically, one of the recommendations for a Region 4 case in September 2018 was to pursue an application for emergency funding and assistance from “3CT”, which is reportedly defunct.

DBHDS’s analysis of RST data for FY17 suggested that the most frequent barrier to a placement in the most integrated setting was: “residential setting unavailable in the desired area”. In the last quarter of FY 18 DBHDS reported “AR reluctance” and “residential setting unavailable in the desired area” as the most frequent barriers to placement in the most integrated setting. In the first quarter of FY19, RST data showed “Individual chooses less integrated setting” and “services unavailable in desired location” (new terminology) as the most frequent barriers statewide to

placement in the most integrated setting. Finally, for this most recent quarter, RST data and reporting drilled down further into Regional service gaps, which should be helpful.

DBHDS has generated a statewide approach to addressing service gaps and new slot development, which includes geo-mapping and self-calculating data displays. This strategy is designed to respond to the SA expectation: *The State shall ensure that information about barriers... is aggregated and analyzed for ongoing quality improvement, discharge planning, and development of community-based services. (IV.B.14)* This was developed and implemented out of the DDS's Provider Development Section. It makes data and startup funding available by Region to providers willing to grow the system's most integrated services.

The startup funding, called Jump-Start Funding, is one-time monies (maximum \$50,000 awards from a \$2.5 million fund in FY19) designed to encourage collaboration among providers and to stimulate the growth of needed services and supports by illustrating to providers where growth opportunities and gaps exist. At this time growth opportunities are fully incorporated for new, integrated supports and services. System gaps data is expected to be incorporated later in the year. The overall strategy, the mapping tools down to region, county, or city, and the funding have been competently designed and, when the results are assessed, may represent a best practice strategy.

In addition, DBHDS has made available NASUAD's (National Association of States United for Aging and Disabilities) *HCBS Business Acumen Center* technical assistance to agencies desiring to expand but wanting improved skill sets in financial competency, business operations, and process improvements. To date 29 agencies interested in growing their lines of business have been participating in this program. Parenthetically, CSBs may apply for Jump-Start Funding but are not involved in the award approval process.

Notwithstanding these advances Community Resource Consultant (CRC) functioning continues to miss the formalized aspects of 'ongoing planning and development of community-based services'. Once centralized planning has improved, local and regional planning will need enhancement.

Summary of Findings

Findings from this review indicate that the overhaul of the RST process this past summer has the potential to have positive impacts on the system. However, for the RST system to work effectively, CSBs must submit referrals to the RSTs as required. In general, individuals, who were referred in a timely manner to the RST, tended to be placed in more integrated settings.

The revised DDS guidance (5.21.18) on when RST referrals are required includes NF, GH5 and ICF/IDD admissions. Since NF admissions undergo the DBHDS PASRR process, we did not expect, and did not find, any RST reviews of the NF admission of four (4) Region 2/4 children for the October 2017- August 2018 period. PASRR data on NF admissions for adults was not available, and only two RST reviews occurred for adult NF admissions for this same period. There may be a need to clarify the role of the RSTs and NF placement.

The RSTs are carrying out functions that support the goal of placement in the most integrated setting possible for individuals with Waiver funded services. The impact of the RST process continues to be limited by the delays (and failure) of case manager/support coordinators in making timely referrals. The RSTs effectiveness in fulfilling their role continues to depend on the timeliness of referrals.

One of the continuing most frequent reasons that larger congregate settings are chosen by individuals and their Authorized Representatives is because they are available in their home communities, whereas there is an absence of more integrated settings located in their home communities. The lack of more integrated models of services is more pronounced for individuals with intense medical and behavioral needs. A clear DDS plan for development and Jump-Start Funding should begin to redress this core problem. Improved, more detailed RST reporting on regional gaps will be especially useful when gap identification is incorporated into geo-mapping reports. Without offering substantially more services in integrated settings it will be difficult to meet the Settlement Agreement requirement that, “to the extent that the Commonwealth offers services to individuals with intellectual and developmental disabilities, such services shall be provided in the most integrated setting appropriate to meet their needs”.

Recommendations:

DBHDS should establish an aggregate goal that Case Managers will submit 95% of referrals to residences of five or more with sufficient lead time to allow the Regional Support Teams to function consistent with the requirements of the Agreement.

DBHDS should require corrective action plans from the CSBs from which Case Managers fail to submit at least 85% of timely referrals quarterly to the RSTs.

Suggestions for DBHDS Consideration

DBHDS should consider examining WaMS service authorization data for those occasions when a billing for a GH5 is first submitted. A flag could be placed in the billing process to reject/pend GH5 claims, if a placement has not been RST approved.

DBHDS should continue to prioritize technical assistance for case managers/support coordinators and their supervisors, who are “forgetting” to provide early referral to RST when individuals or their representatives are considering congregate settings, including NFs and ICFs.

DBHDS should ensure that RSTs are aware of changes to the crisis funding process, including the defunct status of the 3CT. One of the recommendations for a Region 4 case in September 2018 was to pursue application for 3CT funding and assistance.

DBHDS should consider labeling RST referrals after the move has occurred as a ‘default’ rather than a ‘late’ referral to distinguish strategic late submissions in their quarterly and annual reports.

To identify those that consistently perform below standards, DBHDS should consider breaking down late referrals by Region and by CSB in their quarterly and annual reports.

Attachment A

RST Settlement Requirements

III.D.6

Community Living Options

6. No individual in the target population shall be placed in a nursing facility or congregate setting with five or more individuals unless such placement is consistent with the individual's needs and informed choice and has been reviewed by the Region's Community Resource Consultant and, under circumstances described in Section III.E below, by the Regional Support Team.

III.E.1-3

Community Resource Consultants and Regional Support Teams

1. The Commonwealth shall utilize Community Resource Consultant ("CRC") positions located in each Region to provide oversight and guidance to CSBs and community providers, and serve as a liaison between the CSB case managers and DBHDS Central Office. The CRCs shall provide on-site, electronic, written, and telephonic technical assistance to CSB case managers and private providers regarding person-centered planning, the Supports Intensity Scale, and requirements of case management and HCBS Waivers. The CRC shall also provide ongoing technical assistance to CSBs and community providers during an individual's placement. The CRCs shall be a member of the Regional Support Team in the appropriate Region.

2. The CRC may consult at any time with the Regional Support Team. Upon referral to it, the Regional Support Team shall work with the Personal Support Team ("PST") and CRC to review the case, resolve identified barriers, and ensure that the placement is the most integrated setting appropriate to the individual's needs, consistent with the individual's informed choice. The Regional Support Team shall have the authority to recommend additional steps by the PST and/or CRC.

3. The CRC shall refer cases to the Regional Support Teams for review, assistance in resolving barriers, or recommendations whenever:

- a. The PST is having difficulty identifying or locating a particular community placement, services and supports for an individual within 3 months of the individual's receipt of HCBS waiver services.*
- b. The PST recommends and, upon his/her review, the CRC also recommends that an individual residing in his or her own home, his or family's home, or a sponsored residence be placed in a congregate setting with five or more individuals.*
- c. The PST recommends and, upon his/her review, the CRC also recommends an individual residing in any setting be placed in a nursing home or ICF.*
- d. There is a pattern of an individual repeatedly being removed from his or her current placement.*

IV.B.14

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

IV.B.15

In the event that a PST makes a recommendation to maintain placement at a Training Center or to place an individual in a nursing home or congregate setting with five or more individuals, the decision shall be documented, and the PST shall identify the barriers to placement in a more integrated setting and describe in the discharge plan the steps the team will take to address the barriers. The case shall be referred to the Community Integration Manager and Regional Support Team in accordance with Sections IV.D.2.a and f and IV.D.3 below, and such placements shall only occur as permitted by Section IV.C.6.

IV.D.3

The Commonwealth will create five Regional Support Teams, each coordinated by CIM. The Regional Support Teams shall be composed of professionals with expertise in serving individuals with developmental disabilities in the community, including individuals with complex behavioral and medical needs. Upon referral to it, the Regional Support Team shall work with the PST and CIM to review the case and resolve identified barriers. The Regional Support Team shall have the authority to recommend additional steps by the PST and/or CIM. The CIM may consult at any time with the Regional Support Teams and will refer cases to the Regional Support Teams when:

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

APPENDIX F.

OFFICE OF LICENSING /OFFICE OF HUMAN RIGHTS

INVESTIGATION REQUIREMENTS

BY: Ric Zaharia Ph.D.



Consortium on Innovative Practices

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

Licensing and Human Rights
Requirements of the Settlement Agreement

By

Ric Zaharia, Ph.D.

October 26, 2018

Executive Summary

At the request of the Independent Reviewer, this writer conducted a fifth review of the Office of Licensing (OL) and a fourth review of the Office of Human Rights (OHR). These entities represent the Commonwealth's primary system for ensuring the health and safety of individuals receiving services. Therefore, the effective functioning of OL and OHR in accordance with the requirements of the Settlement Agreement (SA) is central to the goal of improving the lives of people with intellectual and developmental disabilities (IDD) in Virginia.

The final version of the revised OL Rules and Regulation implemented September of 2018 shows an improved alignment with the provisions of the Settlement Agreement, including a clarification of expectations around root cause analysis, risk triggers and thresholds, risk management programs, and quality improvement programs. This version includes criteria that partially align with the Settlement Agreement's requirements for an assessment of the 'adequacy of individualized supports and services'.

The OL system is the primary compliance mechanism for Community Service Board (CSB) performance under their contracts with the Commonwealth for the case management/support coordination function. The trend found in 2016 and 2017 of a substantive focus by OL on CSB (Community Service Board) citations and corrective actions by OL for case management/ support coordination problems continued into FY18.

Since DBHDS created and made available the Data Warehouse, OL regularly compiles the results of licensing reviews into statistical reports related to compliance patterns across CSBs and other provider agencies. These reports have improved in their focus and their effectiveness in impacting service delivery. With the upcoming addition of five positions (including quality data staff) to the OL complement, the ability of DBHDS to track and identify licensing trends will continue to improve. The Department's QIC (Quality Improvement Committee) minutes reflect review of those, and other, data analytics, in order to develop system improvements.

OL postings indicate that one IDD provider setting has been placed on provisional status so far during FY19. However, the trend of a number of providers self-selecting out and surrendering their licenses under scrutiny continues. It is doubtful that these two paths to ensuring quality provider agencies can keep up with the need to resolve the concerns presented by the minority of providers who deliver marginal services.

The OHR Abuse Allegation Report database has continued to improve due to the implementation of the retrospective look-behind process. Two provider investigations were reviewed and found to be consistent with best practices. Provider investigators were interviewed and found to be well trained and organized as to their approach to investigations. They reported that OHR technical assistance was very helpful.

This reviewer continues to be encouraged by the investments and actions undertaken by DBHDS over the last few years to improve the effectiveness of both the Office of Licensing Services and the Office of Human Rights. In particular, the addition of regional managers and analytics staff to the OL work force is, and will continue to, enhance Licensing's effectiveness at ensuring quality.

Office of Licensing

Methodology:

- Reviewed selected CSB investigations/surveys/CAPs for April-June 2018 where compliance problems with case management requirements were identified;
- Reviewed selected provider investigation/surveys/CAPs for April-June 2018 where compliance problems were identified;
- Reviewed Q4 FY 18 and Q1 FY19 OL/QIC Quality Improvement Report, plus 4 trend reports, undated;
- Reviewed Quality Improvement Committee (QIC) minutes and actions taken in 2018;
- Reviewed final approved draft of revised *Rules and Regulations for Licensing Providers* (9.1.18);
- Reviewed OL analyses: *Emergency Reg. Monitoring & Emergency Reg. Changes*, undated;
- Reviewed draft OL paper, *Ensuring Adequacy of Individualized Supports*, undated;
- Reviewed OL training power points (*Overview, Risk Management & Quality Improvement, Serious Incident Reporting*) October 2018;
- Reviewed OL Managers Meeting minutes/agendas, June-August 2018;
- Reviewed DBHDS *Guidance on Quality Improvement Programs* (8.6.18) and *Serious Incident Reporting* (8.6.18);
- Reviewed OL participants in LRA Investigator Training, 2018;
- Reviewed OL letter to 10524 denying renewal of provisional license, 9.8.17;
- Interviewed OL leadership.

Findings:

Revised Licensing regulations (12VAC35-105-10 to 1410) were approved for implementation in September of 2018. The final draft changed language in at least sixteen areas: revised incident reporting requirements, clarified licensing statuses, updated DD and ID definitions, added requirements for providers regarding data sharing, upgraded risk management programs (including root cause analysis, monitoring reports, death reviews), quality improvement programs, and ISP (Individual Support Plan) requirements. The revised regulations also include a partial assessment of the ‘adequacy of individualized supports and services’ (Settlement Agreement, V.D.3); Table 1 below attempts to show the alignment of this section of the Settlement Agreement (SA) and the new Regulations.

Table I
SA Alignment with Regulations:
Assessing Adequacy of Supports

Settlement Agreement: V.D.3		12VAC35-105-
a	Safety and freedom from harm	1240-12
b	Physical, mental and behavioral health and well-being	1240-11
c	Avoiding crises	--
d	Stability	--
e	Choice and self-determination	1245-iv
f	Community inclusion	1240-1
g	Access to services	--
h	Provider capacity	--

OL training and orientation to the new regulations began this past summer. The plan for the rollout of training on the major regulatory changes in this revision included an all day training meeting in August for Licensing Specialists. Webinars are planned for the training of providers across the state in late fall 2018. Following the webinars, which will include Q&A sessions, a FAQ (Frequently Asked Questions) guide is planned to be distributed to providers with the opportunity for more local technical assistance by regional managers from OL. A non-citation grace period is planned for the changed regulations, in order to allow for familiarization and to determine additional needed technical assistance. This grace period should expire in January, when full citations will be initiated on the new regulations.

In support of these efforts, OL has developed summary crosswalks (a. identifying and clarifying changes in the new regulations and b. monitoring the new regulations for compliance) and training power points (a. risk management, b. quality improvement, and c. serious incident reporting). In addition, guidance documents for *Serious Incident Reporting* and *Quality Improvement Programs* have been generated with input from the provider community to support the system in addressing these two areas of regulatory change.

Since the availability of the Data Warehouse, OL regularly compiles the results of licensing reviews into statistical reports related to compliance patterns across provider agencies. OL trend reports to the QIC (Quality Improvement Committee) in the past have shown that citations for neglect and abuse have been among the most frequent. For the most recent available time period (April - September 2018) under the old regulations, the most frequently cited regulations were Human Rights -Abuse, Neglect, Exploitation (150.4), ISP updating/review (675.B), and ISP progress notes (680). The continuing frequency of human rights violations merits additional scrutiny.

In addition, past OL trend reports (2016) suggested that timely reporting of serious incidents (i.e. within 24 hours) has been about 86-88%; reports on deaths appeared to be timelier at 92% of the time. Recent OL trend reports (July-September 2018) indicate an improved timely reporting rate of 92% for all serious incident reports (2880 reports) and 91% for reports of death (97 deaths).

OL is the primary compliance monitoring mechanism for Community Service Board (CSB) performance under their contracts with the Commonwealth for the case management/support coordination function. Sixteen (16) CAPs citing CSBs (or their subcontractor agencies) were required by OL during the quarter April - June, 2018. For this review the writer selected ten (10) of those CAPs to review based on selections across four (4) Regions, from among CSBs, who underperformed on Data Dashboard metrics for face-to-face case management in 2017, and from among CSBs that met Data Dashboard metric targets for face to face case management in 2017. Four (4) of these were for late reporting of incidents, six (6) appear to be related to DD case management sub-contractors, and five (5) were subsequent to a death. That eight (8) of the ten (10) occurred subsequent to incidents constitutes a continuing focus of OL on case management compliance and performance monitoring. However, a balance between case management CAPs issued subsequent to a death or a late report, which is appropriate but reactive, and case management CAPs issued pursuant to a regular CSB survey inspection, which is constructive, is optimal.

OL data for 2018 continues to show a significant voluntary settings closure rate. From April – June 2018 thirty-five (35) agencies closed one or more services or settings; from July – September 2018 twenty-seven (27) agencies closed one or more services or settings. It is a positive byproduct of system oversight when many marginal agencies self-select to surrender a license. For example, Provider 10524 closed its residential license effective 5.31.18, after being denied continued provisional status and being placed on provisional status 3.3.17 for failure to submit multiple, acceptable CAPs going back to 2016. However, as we’ve pointed out before, many of these closures are strategic business decisions by agencies rather than responses to regulatory oversight.

This reviewer selected twenty-six (26) CAPs from the April- June 2018 quarter were selected for additional review from among the 200 residential CAPs closed in this quarter. This sample was drawn from CAPs involving an OHR advocate (6), a complaint (2), late reporting (5), medication issues (4) or ISP issues (9). Licensing Specialists appear to be consistently requiring double loop corrective action by providers; that is, expecting providers to correct the immediate citation or circumstance and to also establish processes to ensure this type of citation or circumstance is less likely to occur going forward. This review found that more providers appear to have used a root cause analysis approach to corrective action planning. A few providers also escalated their corrective actions for repeatedly late reports by disciplining (as opposed to re-training) employees.

OL reports indicate that only one ID provider setting was placed on provisional status during the first quarter of FY 19. Assigning provisional status to a license continues to be the most likely OL response to providers who have not been able to modify their practices pursuant to a CAP. However, as reported previously, OL appears to have the necessary regulatory tools to force improvements among substandard providers and to eliminate substandard providers who have demonstrated a refusal or inability to improve their services. There is no evidence to contraindicate the view that there is a continuing systemic reluctance by DBHDS to pursue the use of corrective tools at their disposal. This author has previously suggested that this may be due to the heavy due process burden placed on Licensing Specialists who may be considering corrective action beyond CAPs. Regardless of the rationale, OL has continued to not use all the tools that it has available for sanctioning providers, which results in marginal providers continuing to operate services. It is doubtful that this provisional path, and provider self-selection, can keep up with the need for managing the problems of the minority of providers who deliver marginal services.

As previously reported, case management checklists used by OL do not include a full assessment of the “adequacy of individualized supports and services” per the Agreement. Current checklists are documentation-focused rather than outcome-focused and do not include specific probes of: identifying risks to the individual, assembling professionals and non-professionals who provide supports, and amending the ISP when needed. However, CSBs have been assessed and cited for one or more of these provisos.

This past year DBHDS engaged a national firm, LRA (Labor Relations Alternatives), to conduct investigation training for their staff. Thirty-three (33) Licensing Specialists and other OL staff received this training. Similar training is not planned for the private or CSB sector. However, as discussed below in interviews with local agency investigators over two study cycles, they appear well trained and competent.

Suggestions for Departmental Consideration:

OL should consider a verification audit in annual inspection surveys in which CSB supervisors are asked to review one record in the OL sample and assess adherence to the eight items at V.D.3 of the Agreement; alternatively, add these eight items to the quarterly supervisor surveys via Survey Monkey.

OL should monitor CAP data for case management to ensure a balance between case management CAPs issued subsequent to death or late reports, which is appropriate but reactive, and CAPs issued pursuant to a regular inspection, which is more likely to be constructive.

The QIC should evaluate the root causes for the frequency of human rights violations among OL citations.

OL should consider developing a Licensing Specialist's toolbox of regulatory and other interventions to deal with providers who are not performing well.

OL should consider adopting a more formal tracking and closure approach to verifying the implementation of CAPs and monitoring non-responsive CAPs.

OL should consider conducting occasional focus studies on topics of interest from the Data Warehouse.

Office of Human Rights

Methodology:

- Reviewed data on OHR Retrospective Reviews of provider investigations occurring Jan-March 2018;
- Reviewed summaries of 28 OHR Retrospective Reviews of provider investigations of peer to peer neglect or exploitation occurring Jan-March 2018;
- Reviewed OHR Reports: *Community Look-Behind, FY16, Community Look-Behind, CY18, Look-Behind Timeline FY19*;
- Reviewed OHR Guidance - *7 Things you must know about Community Look-Behind...* (undated);
- Reviewed OHR Guidance (6/15/17) - *Peer-to-Peer Reportable Incidents*;
- Reviewed Investigations Training Manual, undated;
- Reviewed Human Rights Protocol Training Manual, Sept 2018;
- Reviewed VDSS APS/CPS protocol, 7.6.17;
- Reviewed OHR participants in investigation training (Labor Relations Alternatives);
- Interviewed two agency's investigators re: allegation of peer to peer abuse and allegation of exploitation from FY18;
- Interviewed OHR leadership.

Findings:

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

As a quality improvement strategy OHR initiated retrospective look-behinds of a sample of provider investigations from closed cases from 2016. OHR continues these sampling reviews and was able to generate 360 case reviews distributed across five Regions in the past year. These latest reviews included a planned inter-rater reliability assessment component. Technical assistance efforts to improve the quality of provider investigations are provided by the OHR regional advocates at the time of the look-behind. The OHR look-behind is a well-done focus review that results in, and includes, Action Plans based on OHR findings.

However, as we previously noted, the fact that these are retrospective reviews, which in many cases will be 6-12 months following an investigation (which is an improvement over previous years), suggests that the information and feedback to the provider agency may be stale, investigative personnel may have changed, or direct support staff may have turned over. Two agency investigators, who were interviewed by phone for this study, reported nonetheless that the TA they received relative to the cases reviewed was helpful. These investigators, when interviewed, were also found to be well trained and organized as to their investigations.

In the most recent *Look-Behind Report* (March 2018) OHR noted that, against their own 86% benchmark, problems were identified in: timely reporting of CHRIS incident reports, documentation of interviews/witness statements, evidence of action taken by the provider, documentation that investigation findings were shared with the individual or AR, and the absence of recorded formal training of investigators. To address these and other operational issues OHR revised the New Provider On-Boarding process to include review of OHR policies, developed guidance documents for use by OHR staff when providing technical assistance, generated a Decision Tree, published a Complaint Resolution process map, revised their interagency protocol with the Department of Social Services on referrals and joint investigations, and updated protocols with OL re rights violations.

DBHDS contracted with a well-known national vendor of investigator training, Labor Relations Alternatives (LRA). The contract was limited to OL, OHR and other state staff. Twenty-one (21) OHR staff were trained. There is no plan for private sector or CSB provider investigator training; however, there appear to be multiple learning opportunities either through self-instruction or classroom training for provider agencies.

Suggestions for DBHDS consideration:

OHR should consider conducting more contemporaneous look-behinds that occur soon after case closure in rolling time periods, in order to provide more timely feedback.

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

Attachment A
Settlement Agreement Requirements for OL and OHR

III.C. 5. Case Management

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

V.C.3 & 6

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

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

V.G.1-3

G. Licensing

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

APPENDIX G.
MORTALITY REVIEW
BY: Wayne Zwick M.D.

To: Donald Fletcher, Independent Reviewer

From: Wayne Zwick, MD

Re: Mortality Review

Date: October 20, 2018

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

This is the report of the 13th review period to assess the status of the Commonwealth's planning, development, and implementation of the Mortality Review Committee (MRC) membership, process, documentation, reports, and quality improvement initiatives to comply with the mortality review provisions of the Settlement Agreement. The review encompasses nearly a full year of progress and change (October 2017 through August 2018).

Methodology

The findings and conclusions of this review are based on information obtained during interviews with administration and staff from the Department of Behavioral Health and Developmental Services (DBHDS): Alexis Aplaska, MD, FAAP, Chief Clinical Officer; Dev Nair, PhD, Assistant Commissioner for Quality Management and Development; Marion Greenfield, MA, MHA, Director Facility Quality Management, Risk Management, Health Information Management; Renay Durham, LPN, RHTS, MRC nurse reviewer (staff support); Jodi Kuhn, Director Data Quality and Visualization; Susan Moon, RN, BSN, RN Care Consultant, Integrated Health Services; Whitney Queen, MRC Coordinator, and Jamie Sacksteder, Associate Director of Licensing.

Additionally, the following documents were submitted and reviewed:

Mortality Review Committee Meeting Agendas: 10/25/17, 11/08/17, 11/27/17, 12/13/17, 12/27/17, 01/10/18, 01/24/18, 02/01/18, 02/14/18, 02/22/18, 03/01/18, 03/08/18, 03/15/18, 03/29/18, 04/12/18, 04/26/18, 05/03/18, 05/10/18, 05/17/18, 05/24/18, 05/31/18, 06/07/18, 06/21/18, 06/28/18, 07/19/18, 07/26/18, 08/02/18, 08/09/18, 08/16/18, 08/23/18, 08/30/18.

Mortality Review Committee Meeting Minutes: 10/11/17, 10/25/17, 11/08/17, 11/27/17, 12/13/17, 12/27/17, (01/08/18), 01/10/18, 01/24/18, 02/01/18, 02/14/18, 02/22/18, 03/01/18, 03/08/18, 03/15/18, 03/29/18, 04/12/18, 04/26/18, 05/03/18, 05/10/18, 05/17/18, 05/24/18, 05/31/18, 06/07/18, 06/21/18, 06/28/18, 07/19/18, 07/26/18, 08/02/18, 08/09/18, 08/16/18, 08/23/18, and 08/30/18.

The completed Mortality Review Presentation Forms (MRPF) for the individuals discussed at the MRC meetings.

The Virginia DBHDS Annual Mortality Report State Fiscal Year 2017: Mortality Among Individuals with a Developmental Disability

Power Point Presentation: Death Certificates: Quarterly Data Presentation “Incorporating VDH Death Certificates Onto the MRC Tracker” August 2018, Virginia DBHDS

Standard Operating Procedures for the DBHDS DD Mortality Review Committee (prepared 6/12/18)

FY 2017 Mortality Discrepancy file

2018 SFY Mortality Discrepancy file

Mortality Review Tracking Tool FY18

Mortality Review Tracking Tool Oct 2017-Feb 2018

Mortality Review Presentation Form

MRC Samples of Data Warehouse Reports: DW-0064 Incidents, DW-0055 Mortality Report Detail, DW-0025 Death and Serious Injury reporting Time Detail

Action Tracking Log Sept 2017- Dec 2018 Plus Outstanding Recommendations from Previous Tracker

Action Tracking Log Oct 2017 - present.

13th Review MRC Health Alerts Developed as a Result of MRC Recommendations: Sickle Cell, Aspiration pneumonia, congestive heart failure, and stroke,

Health Alerts Developed as a Result of MRC Recommendations (Alerts from Oct 2017 - present (8/8/18)

Health Alerts Developed as a Result of MRC Recommendations (Newsletter Topics from Oct 2017 - present [September 2018]

Newsletter (Virginia DBHDS) “Health Trends” for the following months with featured health alert/focused topics:

October 2017: Bowels: Constipation, C-diff, and Obstruction

November 2017: Diabetes management

December 2017: Aspiration

January 2018: Sickle Cell Anemia, Winter and Extreme Cold Preparation

February 2018: Seizures

March 2018: Congestive Heart Failure, Depression and Suicide, Medication Management

April 2018: Urinary Tract Infections, Safety for Individuals with Autism

May 2018: Stroke, Transportation Safety for individuals in Wheelchairs

June 2018: Choking, Behavioral Changes and Underlying Medical Issues

September 2018: Pica

Power Point Presentation: Tracking Health and Safety Alert Views: Mortality Review Committee, August 30, 2018, Virginia DBHDS

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

Settlement Agreement Requirement

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

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

Findings

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

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

- “identify immediate safety issues ... requiring action ... to prevent deaths, poor health outcomes, injury, or disability in other individuals served
- Identify early warning signs in the change or deterioration of an individual’s medical condition that may help to prevent other negative outcomes.

- Identify conditions contributing to an individual’s death to determine if changes are needed to prevent negative outcomes in other individuals
- Identify system trends or patterns that will serve as the basis for initiatives to improve the quality of care
- Direct training needs to programs and services that serve individuals who are at high risk of injury, illness, or death.

The role of the Mortality Review Committee is to:

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

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

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

The DBHDS Mortality Review Committee process is designed to provide these outcomes (findings, recommendations, etc.) to the Quality Management Committee and to the Commissioner for review and action.

The mortality review process during phase 1 of the eleventh review period was similar to the process outlined in ‘DBHDS Annual Mortality Report 2014’, except that the 2014 report indicated that the reviews were to occur within 90 days of the death. DBHDS subsequently removed this requirement from its next annual report. Additionally, the ‘Mortality Review Committee Operating Procedures 2017 included the following statement: “If within the 90-day period sufficient information is not available to make a determination about the death, the case shall be closed and the minutes of the Mortality Review Committee shall document the lack of information.” This guidance was intended to satisfy the SA requirement of completing of mortality reviews within 90 days of death, but did not include a process for fulfilling the SA requirement to complete quality reviews to determine the necessary steps to ensure the health and safety of individuals – and to “reduce mortality rates to the fullest extent practicable”. The Departmental Instruction 315 (QM)

13 draft of 10/2017 included two statements which approached the requirements of the Settlement Agreement. Under ‘315-7 Procedures - Central Office Developmental Disability Mortality Reviews’, documentation indicated: the mortality review shall be initiated within 90 days of the death.” and later in this section: “The ... Mortality Review Committee shall meet as often as necessary to ensure that the deaths of all individuals with a developmental disability are reviewed within 90 days of death.” Although this indicated improvement in the understanding of the timeliness of mortality reviews, the wording suggested need for further review to accommodate the commitment made in the SA. The SA states clearly the requirement that the mortality reviews will be completed within 90 days with a report prepared and delivered to the DBHDS Commissioner.

A document entitled “Standard Operating Procedures for the DBHDS DD Mortality Review Committee”, prepared 6/12/18, included several procedures which provided timelines for obtaining information for the mortality review; this would theoretically improve the timing of the completion of the mortality reviews to meet the requirements of the SA. DBHDS created and filled a new position (MRC Coordinator) which is responsible for preparing the annual calendar with specific due dates to meet the mortality review deadlines. A ‘Master Document Posting Schedule’ now allows the tracking of documents, and a late documents log was created to track documents from all offices/department not received by the document posting deadline which was 60-69 days from the date of death. Once all documents have been posted the MRC Reviewer is notified in order for the review to begin. Required documentation of the content of the MRC proceedings is listed. The MRC Coordinator then takes recommendations made by the MRC and tracks them for completion on the “MRC Action Tracking log.” The Standard Operating Procedures has provided clarity to the process, as well as due dates to assist the MRC in reviewing deaths in a timely manner consistent with the SA requirement. Data on the impact of these procedures on timely completion of the mortality reviews will be provided later in this document.

The following review of submitted documents and summary of meetings with DBHDS administrative staff provides an evidence-based synopsis of the quality, scope, and completeness of this process, as of August 2018.

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

Calendar Year	# cases reviewed	Outcome pending	Outcome blank	Pending resolved	Action steps/alerts, etc.
2015	307	48	15	31	75
2016	295	9	57	4	80
2017* (Jan-Mar)	50	2	9	0	23
2017 (Apr-Sep)	91	8	3	5	52
Oct 2017- August 2018	243	26	7	25	125

Currently, a nurse reviewer completes a clinical review, summarizes findings on a standardized form, and then presents this information to the MRC. Since the information obtained from this review is sufficiently complete, when the requested documents are submitted and reviewed, this clinical review process has contributed to a trend of the MRC having fewer pending cases. The current MRC process is focused on gathering a standard packet of information and completing a review of this information in a timely manner (discussed in more detail later in this report). This is a much-improved review process in the 2017 review from what was found during the 2016 review. At that time, the MRC routinely closed cases without sufficient information, which resulted in limiting the quality of the MRC reviews and undermining its ability to fulfill both its purpose and the requirements of the Agreement. Overall, the MRC continues to complete reviews with more information (discussed in more detail in this report). Fewer of its cases are now closed when there is insufficient information.

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

DBHDS was provided legal counsel guidance that only the DBHDS Office of Licensing has the authority to review another individual's records in the home. A prior Action Tracking Report July -Sept 2017 reflected this information. Additionally, a prior submitted document, the 7/19/17 MRC minutes indicated the need to discuss criteria for Licensing Specialists to use to determine if medical consultation is needed "to determine if other individuals in the home may be at risk." Although, providing clinical consultation rapidly to Licensing Specialists, when needed, could provide a rapid review that ensures the health and safety of housemates, there was no documentation that any action had been taken to implement this recommendation. Without the appropriate training and experience, Office of Licensing staff may not expand the review to include other individual's records in the home, nor focus on critical medical and nursing concerns.

Settlement Agreement Requirement

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

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

Year of MRC review	Total	Expected deaths	Unexpected deaths	Blank/pending/other
2013*	179	56	123 (68.7%)	
2014	226	75	151 (67.8%)	
2015	290	92	198 (68.3%)	
2016	325	109	212 (65.2%)	4
2017 (Jan-Mar)	50	17	28 (56%)	6
2017 (Apr-Sep)	91	25	61 (69%)	5
2017-18 (Oct-Aug)	243	91	144 (59%)	8

*From 2014 Annual MRC Report DRAFT

This table reviews the decisions by the Mortality Review Committee as to the categorization of each death reviewed as expected or unexpected. The average of unexpected deaths as a percentage of total deaths during the most recent year reviewed has been similar to the percentage of total deaths in prior years (2013-onward).

Year	# meetings	Months without meeting
2015	12	Jan, Aug, Sept
2016	19	Apr, May
2017 (Jan - March)	5	None (all months had meetings)
2017 (April-Sept)	14	None (all months had meetings)
2017-18 (Oct-Aug)	32	None (all months had meetings)

DBHDS held at least one Mortality Review Committee meeting each month since June 2016. For the prior year reviewed (October 2017 through August 2018), there were a minimum of two MRC meetings per month.

Year	Attendance range at meetings	Average attendance
2015	5-10	7.4
2016	6-12	7.5
2017 (Jan - March)	8-11	9.0
2017 (April - Sept)	7-10	8.5
2017-18 (October-August)	5-11	8.5

Attendance at the Mortality Review Committee remained stable. The average attendance rate increased in the first quarter of 2017, which continued through the second and third quarters. The average attendance dropped slightly in April 2017 through August 2018.

Year	MD	Clinical nurse	Admin nurse	Psych/beh/mental health	Data analyst	QA/QI/risk mgmt.	Licensing	Other	No info
2015	2	2		2	2	2		1	6
2016	1	4	2	1	2	3	2	2	3
2017*	1	2	2	1	2	2	1	2	1
2017**	1	4	2	1	2	4	2	5	0
2017-18***	2	2	3	0	3	5	3	6	0

* January - March

** April- September

*** October 2017 - August 2018

The MRC meeting minutes continue to include the name of each attendee, along with the affiliation and the department which each represents. In the past, this important clarification was located in a separate document entitled ‘Mortality Review Committee, membership/participation’. This information currently is located in each MRC minutes document for ready reference, if needed. This improvement is currently sustained, and reflected in the above table, as there was information concerning degree, title/department designee for each participant. During the most recent year reviewed (October 2017 - August 2018), this information continued to be available in the minutes for each attendee.

It was noted that during the time period of this review (October 2017 through August 2018), the medical director had left and a new clinical director was recruited. For the 32 MRC meetings, only 9 were attended by a physician (28%). Without a physician member, the quality of the MRC reviews is challenged. During this transition and recruitment of another physician, from April 26 through August 16, there was no state MD member. This does not meet the standard of required membership for the MRC, but has been corrected. It is noted that during this time period (April 26 through August 16), the independent FNP attended 3 times,

DBHDS reported that the MRC has recruited “at least one member with the clinical experience to conduct mortality reviews who is otherwise independent of the State.” This position and role have been filled by an independent nurse practitioner. Participation started on April 12, 2018. During the time period 4/12/18 to 8/30/18, there were 17 MRC Committee meetings. Attendance by the independent nurse practitioner was 4 of 17 MRC Committee meetings (24%) from 4/12/18 through 8/30/18. This is an inadequate attendance rate. The SA requires the participation of an independent clinician as part of the MRC mortality review process. Membership of an independent member is only important to achieving the purposes of the MRC if the independent member actually attends most of the MRC meetings (85% or greater). DBHDS has made progress in recruiting an independent practitioner, but needs to ensure regular attendance and participation of this member.

Additionally, the MRC continues to discuss other possible members who may be beneficial to the work of the MRC. A 7/19/17 MRC meeting minutes indicated there was consensus that a representative of the OHR (Office of Human Rights) was to be invited to participate in meeting when an individual’s history included an abuse or neglect investigation. The Virginia MRC Annual Report SFY 2017 indicated that the Assistant Director of Human Rights is now a member of the MRC. Additionally, the DBHDS Chief Psychopharmacologist is also now a member of the MRC. Recruiting such members with specific expertise will provide additional insight and quality to the MRC review process and outcomes.

Settlement Agreement Requirement

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

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

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

Year	Within 90 days	Exceeds 90 days	% compliance
2014	123	103	54%
2015	71	216	24%
1/1/2016-6/30/2016	37	127	23%
7/1/2016-12/31/2016	1	107	1%
1/1/2017-3/31/2017	1	72	1%
4/1/2017-9/30/2017	1	64	2%
10/01/17-8/31/2018	0	241	0%

The process for timely completion of the mortality reviews remains a challenge. During the prior reporting period, the nurse (LPN) reviewer was completing reviews for the deaths that occurred approximately 6 months prior. However, this nurse reviewer had only been in the position for a few months at that time. This nurse reviewer continues to provide detailed reports to the MRC for each death discussed. Although DBHDS anticipated that the MRC backlog would be resolved over the ensuing months, this has not occurred. As of the August 30, 2018 review, deaths from 2/19/18 to 4/2/18 were reviewed (4 to 6 month backlog). There was a second nurse reviewer (RN.MSN, behavioral health RN consultant) during the prior review period, but has not been a second nurse reviewer to assist in reducing the back log during this review period. The concern of continued backlog was brought up in the prior year report to DBHDS and remains to be addressed. DBHDS remains out of compliance in this area as none of the MRC reviews with closure occurred within 90 days of the death. However, the new Chief Clinical Officer has developed an early review process for expected deaths which may significantly reduce the backlog in the near future.

**Table 7
Mortality Review Committee Information Reviewed**

YR	# cases	Pro- gress notes	Med rec	Drs' notes	Nurses notes	IRs	IPP / ISP	Mal tx data	PE record	Death cert	Autopsy	Inter- view
2014	226	NR	0	0	0	0	0	0	0	4	1	0
2015	289	NR	1	1	1	289	3	40	0	2	1	0
2016*	164	NR	1	1	2	161	2	39	1	15	7	3
2017**	108	NR	17	15	6	93	23	29	14	6	1	4
2017***	138	NR	58	29	36	137	76	4	44	21	4	0
2017- 18****	243	231	NR	17	30	235	232	4	63	66	1	0

* 1/1/2016-6/30/2016,

** 7/1/16-12/31/16,

*** 1/1/17-6/27/17,

**** Oct2017-August2018

There has been continued progress in tracking timely submission of available documentation by the MRC coordinator. This has allowed improvement in the quality and efficiency of the review.

Previous reviews found that the content of the Mortality Tracker database for all years reviewed included significant gaps in the availability of important information. Many of the columns were blank. The 2014 Mortality Tracker did not enter that Incident Reports were reviewed, when it would be difficult to review deaths without this essential information. The Mortality Tracker did not appear to capture information that was available to DBHDS. DBHDS also had access to the majority of the documents listed in the tracker for deaths at the Virginia Training Centers, as well as some information obtained through licensing reviews, but the MRC tracker database indicated that this information was not available for the MRC reviews. In 2015, an Incident Report was submitted for every death, but this 100% compliance declined to 86% during the first quarter of 2017. A further key was needed in the MRC Tracker to understand the availability of maltreatment data. For this subject category, it was not clear whether the correct interpretation of the entry “no” meant that no data were collected, or that data were collected but indicated no maltreatment, two very different interpretations. In the prior review period ending in September 2017, additional

changes and significant improvement were noted. DBHDS data analysts had created systems to review the data for completeness, accuracy, and consistency. To improve the completeness and integrity of the data available, DBHDS decreased the number of staff with privileges to enter/edit data, streamlined the review process, and added a layer of review to insure data reliability. There remained a need, however, for definitions for each data field.

During the prior year review period, DBHDS had created a list of documents needed for the review of unexplained or unexpected IDD deaths. The Office of Licensing Services obtained these documents for their own reviews and forwarded copies to the MRC nurse reviewer. This list, entitled 'Office of Licensing - DBHDS IDD Death Mortality Review Committee Required Documents/Reviews,' included 10 document categories (medical records for the 3 months preceding the death, physician case notes for 3 months preceding the death, nurse notes for 3 months preceding the death, most recent ISP, PCP assessment, quarterlies, other daily documentation, MARs, discharge summary, most recent physical exam, case management notes, any evidence of maltreatment related to the death, and, if available, autopsy reports and death certificates). Additionally, the MRC requested brief information as to any licensing issues (i.e., corrective action plans and licensing investigation summary report). To collect complete documentation in a timely manner, MRC established posting periods (i.e., dates when documents and shared information must be posted), the meeting date when the MRC review is scheduled, and the deadline for documentation to be available. The MRC posting schedule template included special status (individual resided in a state facility, SNF, etc.) and the identification of any offices that would potentially contribute to the document collection (i.e., licensing, community integration, integrated health services, etc.). The headings in the "Information Reviewed" (Table 7 above) identify some of the documents that are required for review by the nurse reviewer. For the first 6 months of 2017, the 2017 Mortality Review Tracker reflected significant improvement in the availability of documents needed to complete a quality mortality review.

In the prior review period there were two part-time nurse reviewers. This has currently been reduced to one part-time nurse reviewer. As mentioned in the prior review, a new position was filled, the MRC coordinator, which also is a part time position. This position is responsible for ensuring the efficiency of the MRC process from collection of documents to recording and tracking of follow through of recommendations to completion. The MRC review process appears to have been stabilized, with DBHDS having taken some additional steps to improve clarity and efficiency.

The MRC created the Mortality Review Presentation Form to ensure that all essential components are reviewed and succinctly documented. Such areas include providing a narrative/timeline of events, listing pertinent diagnoses and medications prescribed, completing a checklist of concerns/issues identified by the nurse reviewer, and determining whether required/requested documents were received. It requires separate reporting whether these same documents were reviewed. Although the form's instructions provide for consistency and completeness of the review in preparation for the presentation to the MRC, one area needs further clarification. This involves the breakdown of the content of the 'progress notes' collected. According to the MRC nurse reviewer, these "progress notes" are multi-disciplinary in nature. They include case management notes, physician notes, nurses' notes, etc. One additional concern is that not all categories of notes include the requested prior 3 months of documentation; and recording of these variations does not occur in the mortality review presentation form. As reflected in the chart below, it appeared that important medical information was totally lacking in the reviews (no medical notes and few doctor's and nursing notes). However, the progress notes were not further broken down to reflect what had been received in these categories. This needs ongoing review to clarify the category of

documentation that was received. Because this information is not available, it is difficult to determine the percentage of reviews that had adequate supporting documentation and the percentage of reviews in which further documents would have improved the quality of the mortality reviews that had been completed.

The current process for preparation of documents for MRC review was documented in ‘Standard Operating Procedures for the DBHDS DD Mortality Review Committee’. Pivotal to the process, the MRC Coordinator, queries a data warehouse report (DE-0555-Mortality report - Detail) twice monthly to identify individuals for mortality review. A Master Document Posting Schedule is then updated with this information, along with a document identification deadline, which is approximately 6 days from the date of the master schedule posting, the document posting deadline, which is 6-69 days from the individual’s death, and the date of the MRC meeting for that individual. The MRC members are notified of the master schedule update and is available for completion. Each office, as appropriate, completes document identification by the master schedule deadline. The MRC Coordinator tracks documents received past the due date on a ‘Late Documents Log’. To ensure these documents are forwarded for review, the MRC Coordinator further communicates to the relevant office that has not posted documents in a timely manner. Once all documents are received, the MRC Coordinator notifies the MRC Reviewer that the death is ready for review.

An amended/ enhanced version of the form entitled ‘Mortality Review Presentation Form’ has been developed for completion by the MRC Reviewer for each death. This information is a synopsis of the events surrounding the death of the individual. This critical and concise information is used by the MRC in its analysis and making decisions. If the MRC Reviewer determines that additional documents are necessary before presentation to the MRC, then the MRC Coordinator is notified, who in turn requests the needed documentation. Once obtained, or if it is determined that further documentation is not available, the MRC reviewer is notified to ensure completion of the presentation form for discussion at the MRC. Other clinical staff (physician, nurse practitioner or other designated nurse) are resources to the MRC reviewer should questions arise during the review that need additional clinical expertise.

As mentioned earlier, a recent change that the MRC added to its process is the initial review of the mortality review presentation forms by the Clinical Director, who determines which reviews are categorized as expected deaths. These “expected deaths” are then given a more streamlined mortality review compared with the full reviews of deaths that are categorized as “unexpected”, which includes “unexplained” deaths. The MRC reviewer then presents this information for each individual on the agenda of the MRC. The ‘Standard Operating Procedures for the DD MRC’ further outlines specific determinations that are required to be made by the MRC. These include the cause of death, whether the death was categorized as expected or unexpected, whether the death was potentially preventable and any recommendations or actions to be completed based on the MRC review. If the MRC cannot make these determinations and more information is needed, then the case remains pending until further posted documents are reviewed by the MRC reviewer and presented to the MRC at a future meeting. If the cause of death on the death certificate differs from the MRC’s conclusions, then the rationale for the MRC’s determination of cause is documented in the MRC minutes.

To ensure accuracy and completeness of the process, the MRC Coordinator ensures that information on the mortality review presentation form matches the information loaded into the Mortality Review Tracking Tool concerning basic demographic information, such as date of death,

age at death, the living situation category, as well as whether hospice services were used and, if so, the length of time of such services. The MRC Coordinator provides a list of individuals' deaths to be reviewed by the MRC, along with availability of the mortality review presentation form for each individual, and ensures a sign-in sheet is utilized for each meeting. While each case is reviewed, the Mortality Review Tracking Tool is projected to the MRC members to ensure accuracy and consistency of information provided during the presentation. The MRC deliberations and determinations are recorded in the MRC minutes. To ensure accuracy and completeness, a "Mortality Review Team Minutes' Completion Checklist" was developed for the use of staff completing the minutes to ensure that the minutes are complete. After the MRC meeting, MRC staff update the presentation form when requested by the MRC to ensure consistency of information across documents. This mortality review presentation form is saved on the MRC drive. MRC minutes are reviewed by the MRC coordinator and audited for completion by using the MRC Minutes' Completion Checklist. Once completed, the MRC minutes are also posted to the MRC drive. Content of the MRC minutes includes the list of participants, the MRC deliberation as to the cause of death, MRC classification as to whether the death was considered expected or unexpected, whether criteria were met for closure of the review, whether the death was considered potentially preventable, and a list of any recommendations, which includes identification of the offices assigned to lead completion of the recommendations.

The standard operating procedures also documented the role of the MRC Coordinator tracking recommendations made by the MRC. The MRC coordinator logs the recommendation into the MRC 'Action Tracking Log' which is divided into tabs for the lead offices (Community Integration, Licensing, Integrated Health Services, Facility QM/RM, Medical Director, Community QM/RM and Data Quality and Visualization) assigned responsibility for follow up. The MRC coordinator also sends monthly reminders to these departments to capture any updates in progress on these recommendations. Based on this information the MRC Coordinator sends an MRC Action Tracking Log Quarterly Update to the MRC each quarter. Recommendations that are completed, are categorized as closed, which highlights those recommendations still needing action. Submitted documents which reflected this information included 'Mortality Review Committee-Action Tracking Log Sept 2017 - Dec 2018 Plus Outstanding recommendations from Previous Tracker' and 'Mortality Review Committee: Action Tracking Log (per each office for recommendations pending closure from Feb to August 2018) as well as 'Action tracking log closed items'. This approach provided clarity as to the outstanding recommendations assigned to each office.

As part of the quality of the reviews the MRC has continued to make further improvements in data collection during the prior year. Submitted was a power-point presentation entitled "Death Certificates: Quarterly Data Presentation - Incorporating VDH Death Certificates Onto the MRC Tracker". This was dated August 2018. The power-point included the following comment: "Can we use the VDH data now? Not likely, the answer is no, not yet!" based on data quality issues of completed death certificates. However, the power-point did explain at what point in the review process the MRC reviewer included data from the death certificate. Discrepancies in the death certificate causes and the MRC review determined cause was discussed. The MRC committee has identified that the death certificate is only one source of information. The quality of this information is reviewed in the context of all other information obtained.

Table 8
Mortality Review Committee Documents Reviewed - Part II

Year	# Cases	CM Progress notes	Med record	Doctor's notes	Nurse's notes	Incident Reports	IPP/ISP	Physical Exam record	Death Cert.
2014	226	NR	0	0	0	0	0	0	4
2015	289	NR	1	1	1	289	3	0	2
2016*	164	NR	1	1	2	161	2	1	15
2017**	108	NR	17	15 (14%)	6 (6%)	93 (86%)	23 (21%)	14 (13%)	6 (6%)
2017***	138	NR	58	29 (21%)	36 (26%)	137 (99%)	76 (55%)	44 (32%)	21(5%)
2017-18****	243	231	NR	17 (7%)	30 (12%)	235 (97%)	232 (95%)	63 (26%)	66(27%)

* 1/1/2016-6/30/2016

** 7/1/16-12/31/16

** 1/1/17-6/27/17

**** Oct2017-August2018

It is clear that the MRC has continued to strengthen the process of data collection, review and analysis. However, some concerns were noted with the documentation of the data reviewed. According to information recorded on the Mortality Review Presentation Form, the clinical information actually decreased in frequency of review compared to the prior review period. For instance, in the prior review period 21% of the reviews included doctors' notes, 26% included nurses' notes, and 32% included review of the physical exam on record. For the most recent review period, the reviews recorded less availability and/or review of these documents: 7% of reviews included the doctors' notes, 12% included nurses' notes, and 26% include a recent physical exam for review. However, as noted earlier, the data as recorded may under estimate the clinical documents that were received. At times, the progress notes category has included physician and nurses notes in the received documents, but these data are not reflected in the above chart. It is noted that the reviews almost always included review of the incident reports (98%) and ISPs (96%). Currently, the Office of Licensing staff obtain copies of the documents needed and a copy is provided to the MRC staff for review.

Settlement Agreement Requirement

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

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

As background information, DBHDS finalized and published the annual report ‘Mortality Among Individuals with a Developmental Disability: DBHDS Annual Mortality Report for January 1, 2015 – June 30, 2016’. This “Annual Report”, which included an eighteen-month period, included a review of available MRC data, analysis and a summary of findings. The Report also included several recommendations which were based on MRC findings and which provided direction for future initiatives. The MRC, however, did not include information in its “Annual Report” or in the Mortality Review Committee Tracking document to indicate what action steps have been taken (the Safety Alerts, the assistance/action steps taken in response to deaths in the provider agencies, etc.) to implement MRC’s recommendations. The “Annual Report” did not prioritize needs that the DBHDS Commissioner should consider to facilitate implementation and completion of the MRC recommendations.

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

Most recently, DBHDS released its third annual mortality report (The Annual Mortality Report for July 1, 2016 – June 30, 2017). Aggregated data included causes of death, causes of the ‘other’ category of death, percent of deaths considered expected vs unexpected, use of hospice care, along with several other demographic indicators. There was a section which reviewed follow up of recommendations from the prior SFY 2016 Report. Nine recommendations were listed, and progress or lack of progress was reported on each. The report included progress in 5 of these recommendations at the time of the final report. Also listed were several accomplishments of DVHDS, including development of several educational Alerts, listing the monthly educational meetings conducted by the Office of Integrated Health, a detailed process to obtain documents for review in a timely manner, as well as development of a standardized written format in presentation of death reviews at the MRC, expanding additional information collected for tracking and trending data analysis (such as safety, delay in action, regulations cited, missing/failed equipment, communications breakdown, lack of follow up, failure to provide care, etc.).

The Quality Improvement Committee (DBHDS) currently meets quarterly. Included in review are any MRC recommendations. There were no recommendations forwarded by the MRC for

review in the past year which resulted in action steps being taken. The most recent Annual Mortality Report (July 1, 2016-June 30, 2017) is to be reviewed in the upcoming quarterly meeting.

Settlement Agreement Requirement

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

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

The Office of Integrated Health Services continues to create Safety Alerts, which are distributed by email and are posted on the DBHDS website. Alerts listed in the State Fiscal Year 2017 Annual Report included the following: Breast Cancer Screening, Type I Diabetes, Type II Diabetes, Sepsis Awareness, Fall Prevention, Drug Recall Alert, Flu Season Reminder, Adult Immunization Schedule and Stroke. A more recent list was submitted as of 8/8/18 and included additional topics/updates for sickle cell anemia (undated), aspiration pneumonia (5/10/18), stroke update (5/10/18), congestive heart failure (5/10/18), pica, and recognizing constipation and bowel obstruction. A monthly newsletter provides informational on a wide variety of topics important to the IDD population: wheelchair safety tips, transportation safety for individuals in wheelchairs, handwashing, inclusion, mobile dentistry program, foot care and diabetes, winter and extreme cold preparation, tips for wandering due to dementia, discharge planning, medication management, risks of cardiovascular disease, UTIs, nutrition and wound healing, and behavioral changes and underlying medical issues. The Alerts, which were of high quality, were written for easy understanding by the lay public and included source references. The Office of Integrated Health Services also created one page, “in a nutshell”, summaries of these alerts. The revised Alerts are an indication of a quality improvement approach: the periodic review of whether the implementation of policies and practices that address complex issue can be improved, and, if so to make needed revisions. Without a date of initial implementation or publication, and the dates of revisions (i.e., created xx/yy, revised xx/yy), it could not be determined whether the contents being read were current. There was no information whether there was an established time interval for review of the Safety Alerts. However, OIHS indicated that they do have a tracking system which records all alerts and the date last reviewed. OIHS indicated that its goal was for annual review, but it appeared this had not been finalized.

Settlement Agreement Requirement

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

The team also shall collect and analyze mortality data to identify trends, patterns, and problems at the individual service-delivery and systemic levels and develop and implement quality improvement initiatives to reduce mortality rates to the fullest extent practicable.

Year	2014	2015	2016	7/1/16 - 12/31/16	1/1/17 - 3/31/17	4/1/17 - 6/30/17	10/1/17- 8/31/18
Total deaths	226	289	164	109	73	65	243
Pneumonia	32(14.2%)	21 (7.3%)	17 (10.4%)	6 (5.6%)	17(23%)		30 (12.3%)
Cancer	24 (10.6%)	30 (10.4%)	28 (17.1%)	8 (7.4%)	1	1	20 (8.2%)
Aspiration	17 (7.5%)	19 (6.6%)	4 (2.4%)	6 (5.6%)	1		10 (4.1%)
Sepsis	20 (8.8%)	21 (7.3%)	18 (11%)	6 (5.6%)	1	3	14 (5.8%)
GI	8 (3.5%)	8 (2.8%)	4 (2.4%)	2 (1.9%)	0		9(3.7%)
Respiratory	5 (2.2%)	19 (6.6%)	3 (1.8%)	7 (6.5%)	7(9.6%)		20 (8.2%)
Other	19 (8.4%)	19 (6.6%)	14 (8.5%)	8 (7.4%)	14 (19%)	1	30 (12.3%)
Unknown	47 (20.8%)	58 (20.1%)	22 (13.4%)	12 (11.1%)	11(15%)	2	17 (7.0%)
Respiratory/ pneumonia	37 (16.4%)	40 (13.8%)	20 (12.2%)	13 (12.0%)	24 (33%)	-	50 (20.6%)
Cardiovascular	-	-	-	-	13(17.8%)	-	41(16.9%)
Neurological	-	-	-	-	6(8.2%)	-	19 (7.8%)
Multiple medical	-	-	-	-	-	-	11 (4.5%)
Renal	-	-	-	-	-	-	15 (6.1%)

The ‘Mortality Tracker’, the MRC minutes, and the Mortality Review Presentation Form included valuable data that provide information concerning the most common causes of death. The categories that the MRC is tracking had been expanded to include a category of “multiple medical conditions”. In reviewing the findings in the submitted MRC minutes, the category of death was generally consistent with the information that was provided to the MRC. DBHDS provided a Power Point presentation concerning death certificate information which indicated that during the prior year, the quality of the information in these certificates was at times problematic and not helpful to the MRC in actually defining the terminal cause of death. This review found positive results from the MRC’s work in this area.

The percentage of deaths from pneumonia and combined respiratory/pneumonia had spiked significantly in the prior review period (33%), but appears to have decreased during this review period (20.7%). The cause of death did not change significantly as a percentage of total deaths from prior review periods for cancer, aspiration, sepsis, GI, and neurological. MRC established and added “multiple medical” as a new Cause of Death category to the MRC tracking database. Over all, the unknown category of deaths has continued to decrease over time, from 20.8% in 2014 to 7.1%. Areas of concern such as aspiration, choking, and sepsis have not been reduced significantly, despite Safety Alerts, training across the state by Integrated Health Services, and monthly newsletter articles. To reduce the incidents of these causes of death, some of which are potentially avoidable, will require ongoing surveillance and potentially new approaches. However, the work done to educate providers on these topics has been helpful to the community, as the number of “hits” or

viewers of the website information has indicated interest and value in the content. Maintaining a record of “hits” is a recent advance in determining how often these alerts are used by the providers. OIHS responds to this information by interpreting that an Alert with many “hits” is helpful to the providers. An Alert with few “hits” is considered one needing review or revision. However, there are other reasons determining the size of the audience that reviews posted documents (awareness of how to access the document, one clinical problem may be common, and another uncommon, but both may be well written, timely, and important, etc.).

Recommendation follow-through

At the time of the prior review, the MRC’s quarterly review template entitled “Mortality Review Committee Action Tracking Report July-Sept 2017” was being tested in the second month of its development (October 2017). At that time, the results indicated that all recommendations were being tracked until completion. From July 2017 to August 2018, there were 125 MRC recommendations tracked in this document. As of September 2018, there were only 10 pending recommendations (8%). The remainder had been closed (80%) or did not need additional follow up. It was noted that 50 of these recommendations (40%) were systemic with impact to improve the quality, efficiency, and or effectiveness of the process, or with impact to improve quality of life, health, and safety of the IDD population being monitored.

MRC categorizes the contents of the recommendations according to the office assigned to lead implementation efforts. From the prior review, the documentation from 10/18/17 indicated the following. The Office of Community Integration completed 3 of 3 recommendations. The Office of Licensing completed 4 of 4 recommendations. The Office of Integrated Health Services completed 2 of 13 recommendations. Facility QM/RM completed 4 of 8 recommendations, the Medical Director completed 1 of 2 recommendations, and Community QM/RM completed 1 of 3 recommendations. During this review, the Medical Director, Licensing, Community Integration, Community QM/RM, and Data Quality and Visualization had no outstanding recommendations for closure, Integrated Health Systems had 5 recommendations needing closure, and facility QM/RM had 4 recommendations needing closure. The tracking system indicates that there is now timely follow through of the recommendations until closure.

Summary Bullets

Advances

- MRC consistently occurs twice monthly or more often, if needed.
- Names of attendees with titles and department/ institution affiliation continue to be documented as part of the MRC minutes.
- Data accuracy, consistency, and integrity continues to be reviewed by data analysts.
- A list of documents that providers are required to submit to DBHDS licensing specialists continues to be utilized. Tracking included when the documents were received by MRC administrative staff. Timely inventory of received documents at periodic intervals continues to be part of the tracking process by an MRC Coordinator.
- The MRC Coordinator has been integral to the flow of documentation and timeliness of the many steps in the MRC process.

- A standardized format for mortality reviews continues to be utilized in providing essential information during MRC meetings.
- Information from the death certificates is now regularly available to the MRC.
- The MRC has been expanded to include participation of the Assistant Director of Human Rights and a pharmacy services manager.
- There has been a new MD, Chief Clinical Officer, brought into the department, replacing the outgoing Medical Director. Although only in DBHDS since August 2018, this physician has brought the capacity for strong medical oversight and consistency to the department.
- The Chief Clinical Officer has already made a significant impact in increasing the rate of processing mortality reviews, by introducing a step for The Clinical Director introduced a preliminary step that involves a review to determine deaths that were expected and therefore do not require a full MRC review and discussion.
- A new independent practitioner has been recruited as part of the MRC.
- The quality of the clinical reviews brought to the MRC is generally complete and of sufficient quality to allow the MRC to complete its duties.
- The MRC protocol appears to be back on track to ensure quality mortality reviews when adequate documentation is available. This review did not find that the MRC was closing mortality reviews prior to receiving sufficient data.
- The MRC database management process in populating the Mortality Tracker spreadsheets ensures integrity of the data by limiting staff with approval to enter information.
- The MRC's tracking system to follow through on recommendations to closure continues.
- Safety Alerts are tracked to ensure information is current and are updated if needed.
- OIHS has been able to track the frequency of provider community review of Alerts posted on the website.
- The quarterly reports provided by the Office of Data Quality and Visualization allows for prompt analysis in determining trends rather than waiting for an annual report to be completed and distributed.

Challenges

- Although, the DBHDS Mortality Review Committee has recruited a required member identified with clinical experience in mortality reviews who was independent of the State, attendance has been very low (~ 10% of meetings). MRC members should attend and participate in most meetings, 85% or more.
- The deadline of review within 90 days of death has not been attainable due to the backlog of cases to be reviewed by the nurse reviewer.
- Obtaining information from the community providers has remained a challenge. DBHDS has identified the need to resolve this issue. DBHDS has begun additional steps to improve access to documents from community providers.

- DBHDS needs to review the quality and quantity of clinical documents received for review by the various residential settings. The provider residential settings' health care plans need to be based on access to physician records, test results, and hospital discharge summaries, with focus on critical diagnoses of the individuals in all residential settings. Quality of health care plans may be inconsistent in quality and clinical depth across the various provider network.
- The Mortality Review Presentation Form needs further revision to capture the actual documents the MRC received and brief documentation of the category of any licensing deficiency found at the provider.
- The MRC was developing a trigger tool to guide Licensing Specialists in determining when they need to seek consultation with an RN. This concern has been identified previously and remains a significant outstanding concern. There was no further information as to whether this was finalized or put on hold.
- The DBHDS produced Safety Alerts continue to be developed. However, some of the submitted examples continue to not have dates when they were created or when they were revised.
- The OIHS tracked information concerning the technical assistance that it provided. OIHS does not yet track whether training has achieved the expected and desired outcome.
- The mortality review process did not include a review of potential risk of other individuals in the provider home; DBHDS reports that only the OLS has the authority to review such cases. A prior recommendation had not yet been implemented to provide Licensing Specialists access to/urgent collaboration with clinical staff to identify immediate safety issues ... requiring action ... to prevent deaths, poor health outcomes, injury, or disability in other individuals served.
- The Quality Improvement Committee has not received any recommendations from the MRC for review during this past year. This is due, in part, to the lack of completing mortality reviews in a timely manner.
- The licensing staff do not generally have a medical or clinical background. During the licensing review process, however, they appear to be required to make medical or clinical judgements for which they are not qualified. DBHDS does not have a formal process to ensure the provision of needed medical/clinical expertise when Licensing Specialists are required to make medical/clinical judgments. It does appear that medical and clinical expertise is available when requested.

Attachment A

Documents submitted during prior review periods which were used as baseline and reference information for this review:

MRC minutes 2015: 2/11/15, 2/24/15, 3/11/15, 4/15/15, 4/17/15(2), 5/27/15, 6/10/15, 6/29/15, 7/10/15, 7/22/15, 10/14/15, 11/23/15, 12/2/15, 12/9/15, and 12/29/15.

2016: 1/27/16, 2/10/16, 3/9/16, 3/28/16, 6/8/16, 6/22/16, 6/30/16, 7/7/16, 7/13/16, 8/10/16, 8/24/16, 9/14/16, 9/21/16, 10/12/16, 11/9/16, 12/5/16, 12/9/16, 12/14/16, and 12/21/16.

2017: 1/11/17, 1/18/17, 2/15/17, 3/8/17, 3/22/17, 4/18/17, 4/26/17, 5/10/17, 5/24/17, 6/7/17, 6/14/17, 6/28/17, 7/19/17, 7/26/17, 8/9/17, 8/17/17, 8/23/17, 9/13/17, and 9/27/17.

2016 Mortality Tracker

2017 SFY Mortality Tracker (as of October 2017)

Draft Community DD Mortality Review Worksheet

'Mortality Among Individuals with a Developmental Disability: DBHDS Annual Mortality Report for January 1, 2015 -June 30, 2016'

Departmental Instruction 315 (QM) 13 Reporting and Reviewing Deaths (draft)

Mortality Review Committee Operating Procedures 2017

Responses to Recommendations from the Independent Reviewer Report to the Court 12-23-16

Mortality Review Committee Membership/Participation (undated)

Numbered Recommendation Status Tracker

Mortality Review Committee tracking 3/15/17

Mortality Review Committee Interventions to Address Concerns

Form letter to Office of Vital Records for copy of death certificate (draft)

Form letter to provider organization requesting specific documents for review (draft)

DBHDS ID/DD Mortality 2013 Annual Report (May 2014 Draft)

DBHDS 2014 Annual Mortality Report (August 2015 draft): 'Mortality Among Individuals with an Intellectual Disability'

DBHDS Mortality Review Letter to Medical Practitioners (October 2015): "Reminding Medical Practitioners of High-Risk Conditions"

Mortality Review Committee data tracking documents: 2014 Mortality Tracker, 2015 Mortality Tracker, and 2016 Mortality Tracker (to 6/30/16)

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

DBHDS Instruction (July 2016 Draft): Mortality Review

Mortality Review Committee: Master Document Posting Process (undated)

Copy of Master Schedule July 2017 (in testing): MRC Master Document Posting Schedule

(MDPS) Posting Period July 2017; Date Master Schedule Posted August 2017

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

MRC Master Document Posting Schedule (MDPS) with drop downs

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

MRC Meeting Minutes Shell 10/16/17

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

Safety and Quality Alerts of the Office of Integrated Health Services: Recognizing Constipation, Type II Diabetes, Type I Diabetes, Sepsis Awareness, Scalding, Preventing Falls, Breast Cancer Screening, Aspiration Pneumonia - Critical Risk, 5/19/17 Drug Recall Alert

Mortality Review Committee: Quality Improvement Plan: CY 2017

Recommendations Status 3/14/17

Quality Improvement Committee Meeting Minutes 7/6/17

2017 Progress Report: Office of Integrated health

Training Data (Skin Integrity Training)

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

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

APPENDIX H.
QUALITY, RISK MANAGEMENT AND TRAINING
BY: Maria Laurence

**Report on Quality and Risk Management
and Training**

United States v. Commonwealth of Virginia

Submitted by: Maria Laurence
Independent Consultant
November 7, 2018

INTRODUCTION

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

The Settlement Agreement also requires the Commonwealth to have “a statewide core competency-based training curriculum for all staff who provide services under this Agreement. The training shall include person-centered practices, community integration and self-determination awareness, and required elements of service training.” (V.H.)

At the request of the Independent Reviewer, this is the sixth Report that assessed the Commonwealth’s progress in meeting these terms of the Settlement Agreement. Maria Laurence previously reviewed and submitted reports that included findings and recommendations related to the Quality and Risk Management and Training systems. These reports were included with the Independent Reviewer’s Reports to the Court, which were submitted on December 6, 2013, December 8, 2014, December 6, 2015, December 23, 2016, and December 13, 2017. For the December 2017 report, Maria Laurence worked with Chris Adams to submit two reports: “Report on Quality and Risk Management” (Quality Report), and “Report on Competency-Based Training” (Training Report), both dated November 10, 2018. Using information from these reviews, and from other sources, the Independent Reviewer made previous determinations of compliance. This report includes references to previous reports, as relevant to recent findings.

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

- 1) Risk triggers and thresholds;
- 2) Data to assess and improve quality;
- 3) Providers; and
- 4) Provider Training.

At the outset, the consultant would like to thank the Department of Behavioral Health and Developmental Services (DBHDS) staff for their time and input. The assistance given throughout the review period by the Assistant Commissioner for Licensing and Compliance, the Chief Clinical Officer, the Community Quality Management Director, and the Director of Provider Development is greatly appreciated. In addition, other Commonwealth staff, staff from two Community Services Boards (CSBs), as well as staff from two community provider agencies participated in interviews and provided documentation. All of these staff’s candid assessments of the progress made, as well as the challenges ahead, were very helpful, and are an indication of their commitment to future progress. The organizational assistance provided by the Senior DD Administrative and Policy Analyst also was of significant help.

METHODOLOGY

The fact-finding for this Report was conducted through a combination of interviews and document review. Between August and October 2018, interviews were held with Commonwealth staff, and staff from CSBs and provider agencies. (Appendix A includes a list of the people interviewed and the documents reviewed.) It is important to note that many of the Commonwealth's Quality and Risk Management System and Training initiatives continue to be in the process of development and implementation. As a result, a number of draft documents formed the basis for this Report.

FINDINGS AND RECOMMENDATIONS

Since the last review, the Commissioner of DBHDS made changes to the organizational structure, including the responsibilities for oversight and implementation of the Department's quality assurance (QA)/risk management and quality improvement (QI) functions. Based on the revised organizational chart, dated 8/24/18, the staff in the following positions hold responsibility for portions of the QA/QI program:

- The Assistant Commissioner for Licensing and Compliance reports to the Deputy for Compliance, Legislative and Regulatory Affairs. This Assistant Commissioner maintains responsibility for Licensing, Regulatory Compliance, Human Rights, Risk Management, Community Integration, Incident Management, and Quality Assurance;
- The Chief Clinical Officer, who reports directly to the Commissioner, has responsibility for Community Quality Improvement, as well as Quality Improvement at the Facilities, Mortality Review, Case Management, and Data Quality and Visualization. At the time of the consultant's onsite visit, the Chief Clinical Officer recently had begun in this position; and
- The Data Warehouse functions currently fall under the Deputy for Administrative Services.

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

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

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

The fact-finding for this Report was designed to:

- a) Determine whether the Commonwealth has established risk triggers and thresholds that enable them to adequately address harms and risk of harms, including:
 - i. Uniform risk triggers and thresholds adequate to identify and to address risks of harm, not only actual harm;
 - ii. Those that may not result in harm; for example, choking, peer assault, and the presence of staff who have not been trained and demonstrated competency to deliver the elements of each individual's services; and

- b) Determine the status of the development of related training for providers.

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

One year ago, at the time of the last Review, the Commonwealth had stopped the development of lists of specific triggers and thresholds, and decided to pursue different options for identifying individuals at risk of or who had experienced harm, as well as providers that might place individuals at risk of harm, and potentially require attention. This represented a shift from a reactive system, which relied heavily on the Commonwealth to identify that a problem had occurred and notify CSBs and/or providers, to a more proactive approach, which combined efforts on the part of the CSBs and providers, as well as Commonwealth staff to proactively identify risk and potential for risk. The Commonwealth anticipated that this revised system also would retroactively address harm that occurred to prevent its recurrence to the extent possible. As of the last Review, Commonwealth staff had drafted a framework for this new approach, but the staff recognized that significantly more work was needed to finalize and implement the framework. DBHDS staff hoped to show more progress with this system over the coming year.

The following provide brief updates regarding each of the components within DBHDS's Draft Community-Based Risk Management Framework:

- 1) Serious incident reports (SIRs) and human rights complaints review: The document described steps needed to harness the information that these existing processes generate, including identifying individuals at risk, as well as providers that require attention; triaging them so that highest priority issues are addressed first; following up on identified issues; and identifying issues that repeat themselves for further analysis and action. Since the last Review, the following summarizes actions the Commonwealth took and/or its planned next steps:
 - a. Based on review of the draft minutes of the 8/27/18 Risk Management Review Committee (RMRC), an updated Incident Management Report was now available using actual data. DBHDS shared a spreadsheet with the Consultant that showed the fields that the Incident Management Report includes, as well as the potential for drilling down into the data. For example, staff could run reports for the entire system, by Region, by CSB, by provider locations, by individual, by type of incident, etc. During the August meeting, the RMRC requested two additional fields: description of medication treatment and findings, and medical attention provided. The group also noted and asked for correction of some discrepancies in numbers of incidents when data were sliced differently.
 - b. Once CHRIS is updated to include levels of incident reports (II-III) to reflect regulatory changes, DBHDS will need to make further updates to the Incident Management Report.
 - c. Next steps include trending of data, analysis of data, and use of the results to effectuate change. According to the August minutes, the five Regional Human Rights Managers were testing the use of the data report. Minutes did not yet show that DBHDS was using the data to identify individuals at risk or providers that require attention; triaging the data so that highest priority issues are addressed first; or following up on identified issues.
 - d. Based on review of RMRC reports, Commonwealth staff also are engaged in a process of attempting to incorporate into the system the recommendations from the Office of Inspector General (OIG) Ensuring Beneficiary Health and Well Being in Group Homes Through State Compliance Oversight Report, dated January 2018.
- 2) Mortality review: To review and follow up on mortality review information at the provider level, the process would be similar to that which the Commonwealth proposes for SIRs. The Independent

Reviewer commissioned another study on mortality reviews, and the report for that study provides additional information on the status of mortality reviews. Neither the RMRC nor QIC minutes the Commonwealth submitted for this Review included reports or analysis of mortality data;

- 3) Health risk assessment: DBHDS proposed identifying one health risk assessment (HRA) and/or common elements of a risk assessment tool that all six managed care organizations (MCOs) would use to determine individuals' risks in key health areas on an annual basis. Once such a tool is implemented across the MCOs, DBHDS could utilize the data for risk management purposes, and work with providers in the development of plans to mitigate identified risks to the extent possible. Since the last Review, the following summarizes actions the Commonwealth took and/or its planned next steps:

- a. In a document entitled: "Commonwealth Coordinated Care Plus MCO Contract January 2018: Excerpts Related to Health Risk Assessment," the Commonwealth provided the following statement summarizing the status, and next steps:

Currently the six MCOs are using different Health Risk Assessments that are proprietary in nature and not available to share during this review. DMAS and MCOs are working to develop one standardized HRA. DBHDS has provided technical assistance to the CSBs that case managers/support coordinators collaborate and establish relationships with individuals [sic] Care Coordinators and request HRAs or identified risks and discuss plan to mitigate those risks. DBHDS has also met with DMAS and MCOs and requested that Care Coordinators share the HRA with case managers/support coordinators, or communicate identified risks and discuss plan to mitigate those risks...
- b. Based on this Consultants' interviews with CSBs, they report having mixed results obtaining information from the MCOs and Care Coordinators regarding individuals' risks and plans to mitigate risk. They attributed this variability to different levels of MCO's willingness to share information that they either consider proprietary or covered under the Health Insurance Portability and Accountability Act (HIPAA).
- c. The excerpts from the MCO contracts require the MCOs to:
 - i. Use an HRA as a tool to develop individuals' person-centered Individualized Care Plans;
 - ii. In 2018, participate in a workgroup that includes representation from all plans, DMAS, and relevant stakeholders. "The goal of the HRA workgroup is to create a universal HRA that is portable and that can follow the Member from one MCO to another."
 - iii. Develop an HRA process to broadly "identify the Member's unmet needs, and... encompass social factors (such as housing, informal supports, and employment), functional, medical, behavioral, cognitive, LTSS [Long-term Services and Supports], wellness and preventive domains, the Member's strengths and goals, the need for any specialists, community resources used or available for the Member, the Member's desires related to their health care needs (as appropriate), and the person-centered ICP maintenance."
 - iv. Make completion of the Uniform Assessment Instrument (https://www.dss.virginia.gov/files/division/licensing/alf/.../uai_users_manual.pdf) part of the process for Commonwealth Coordinated Care Plus (CCC Plus) participants.
 - v. For CCC Plus participants, conduct an initial HRA within 30 days of enrollment, review and update the assessment every six months, and upon a triggering event, such as a hospitalization or significant change in health or functional status.
- d. Next steps include DBHDS exploring with DMAS adding the HRAs the MCOs completed to the Waiver Management System (WaMS) to allow better access to them. DBHDS staff with whom the Consultant spoke understood that in order to use the HRAs to inform the

risk management system, an essential next step was gaining access for DBHDS staff, as well as CSB or other Support Coordinators and interdisciplinary teams (IDTs) to data included in the assessments.

- e. In the 11/28/17 RMRC minutes, the Committee recognized that the risk assessment process is the first step in the risk mitigation process with next steps including the development and implementation of Individual Support Plans (ISPs) that address individuals' risks in a clinically appropriate manner. The meeting minutes state: "An ISP is a shared plan and needs to include activities and supports the individual will need from Care Coordinators, SC/CMs [Support Coordinators/Case Managers], and provider's [sic] to mitigate risk from current and potential complications based on certain medical conditions, lifestyle (diet/exercise). Plans need to be medically sound."

DBHDS shared ISP training modules as well as Person-Centered ISP Guidance, dated 6/15/18. Although the purpose of this review is not to provide detailed comments on these training materials, overall, they provide some basic guidance on identifying health and behavioral health risk, which will need updating as additional risk assessment tools become available. They provide some good guidance on the development of measurable, clinically relevant outcomes/goals, as well as support strategies to address risk. Although the instructions in the training emphasized the importance of developing measurable outcomes and activity statements, not all of the examples the training provided were measurable (e.g., Mary will have "healthy" skin so that she is "comfortable"). In addition, some examples did not address the etiology or cause of the risk (e.g., Jarod is free of choking/aspiration) and/or did not reflect what the individual could do to reduce his/her risk (e.g., slow eating pace, remain upright for an hour after eating, etc.).

- 4) **Provider competency and capacity:** Data for this component would come from a variety of sources, including the Office of Licensing Services (OLS) and Department of Medical Assistance Services (DMAS) citations, completion of Service Coordinator/Case Manager training and competencies, and information about direct support professional and supervisor completion of training and competencies. Since the last Review, the following summarizes actions the Commonwealth took and/or next steps:
 - a. Based on the RMRC minutes, dated 10/26/17, DBHDS requested funding "to develop an online tool to use in evaluations with weighted responses that will lead to innovation and best practices. It is planned that this system will include:
 - A provider data base that is rated per scorecards and posted on the website
 - Provider self-assessment (quality of services, staff competency, outcomes, person centered planning, etc.)
 - Validation of provider self-assessment results by DBHDS."
 - b. The meeting minutes, dated 12/19/17, indicated DBHDS continued to pursue a quality management rating system to measure the quality of services and supports community-based providers offered. However, recent updates did not illustrate progress on this project.
 - c. As discussed elsewhere in this report, the QIC and Regional Quality Councils reviewed some licensing citation data reports, but overall, the system has not yet established and continues to work on the best ways to use this data as part of its risk management and quality improvement systems.
 - d. As discussed with regard to training, although CSBs and other providers reported that they maintained various systems to track the completion of direct support professional and supervisor competencies, DBHDS did not have a system for collecting or reviewing these data, or confirming that trainings were competency-based or that they accurately measured staff's competence.

5) Provider quality improvement and risk management framework: The first step listed to obtain relevant data for this component was the development of a **QI**/risk management framework. Once completed and implemented, the Commonwealth proposed monitoring providers and CSBs' implementation, and then reporting on specified metrics. Since the last Review, the following summarizes actions the Commonwealth took and/or next steps:

- a. **DBHDS** provided a document entitled: "Draft Resource Tool to Develop a Provider Quality Improvement/Risk Management (**QIRM**) Framework" (**QIRM** framework). Based on interviews with Commonwealth staff, their intent was to provide a tool that set forth a basic framework for a risk management system that the smallest to the largest CSB or provider could use. Staff did not intend for this document to provide the floor for what **DBHDS** minimally requires, but rather to lay out a comprehensive view of quality improvement and risk management methodologies.

This 27-page draft document provides the regulatory backdrop for the development of risk management and quality improvement systems, as well as descriptions of the leadership structure, and the strategies and processes that providers can use to mitigate risk to the extent possible. For example, it provides explanations of and resources on topics such as risk assessment, quality improvement/risk management plans, performance and outcome measures, and data analysis.

As discussed during onsite meetings, the **DBHDS** staff who worked on the document did a nice job of compiling important information about risk management systems, and identifying a large array of potential resources to assist providers as they develop or refine their systems. However, based on the Consultant's interviews with CSBs and providers during this and previous Reviews, two concerns surface:

- i. CSBs and providers need guidance on the minimum requirements of a risk management system, which **DBHDS** staff report is not the intent of this document; and
- ii. Because of its comprehensiveness, the document would likely overwhelm many providers and CSBs, particularly those who are struggling to develop basic, reasonable, and appropriate risk management systems.

During the onsite interview, the Chief Clinical Officer suggested that **DBHDS** might consider revamping the document into a tool kit format with multiple segments. The Consultant agrees that breaking the information down into more usable parts would make it more likely that CSBs and providers of all sizes could/would use it to improve their risk management systems. A tool kit format also would offer **DBHDS** with the opportunity to provide practical examples of what the various processes or methodologies might look like in different-sized organizations.

- b. In addition, in terms of next steps, **DBHDS** should consider developing and disseminating criteria for the requirements of a risk management system. In addition to addressing CSBs' and providers' concerns about expectations, specific criteria are needed to allow the Commonwealth to consistently monitor providers' and CSBs' implementation and adherence to, at least the minimum, requirements. Based on review of **RMRC** minutes, **OLS** developed "Guidance for a Quality Improvement Program," but **DBHDS** did not provide this document for review, and its status was unclear.

As indicated in this Consultant's last Report, given the size and structure of the Virginia intellectual and developmental disabilities (ID/DD) system and the need to develop a sustainable risk management system, the Commonwealth's plan to work with CSBs and providers to structure their risk management systems, and then to develop mechanisms to ensure those systems are working correctly is a reasonable one. Although the general framework and components that the Commonwealth outlined have the potential to generate useful data to identify potential risk of harm and realized harm, at the time of the current Review, staff made some progress, but substantially more work is needed to actualize a functioning system.

Since the last Review, the Commonwealth's RMRC increased the frequency of its meetings from approximately every two months to monthly. According to the minutes for the meeting held on 7/27/17, the group agreed that it needed a charter to define the purpose, membership, responsibilities (e.g., reports/data it should review, follow-up it should undertake, etc.), and the group's relationship to other committees, such as the Quality Improvement Committee (QIC), and Mortality Review Committee (MRC). As of the meeting held on 4/30/18, the charter was still being developed. It does not appear that the charter has been developed further as subsequent meeting minutes did not provide updates.

At this juncture, the RMRC has played a role in discussing the overall risk management framework that is under development. The group also regularly reviews and tracks completion of recommendations from the Independent Reviewer's SIR review report recommendations.

As past Reports indicated, the Commonwealth's regulations provided significant obstacles related to implementing a system-wide risk management and quality improvement system, because of what they did not require from private providers. On a positive note, the revised regulations added or revised the following paragraphs:

The provider shall conduct systemic risk assessment reviews at least annually to identify and respond to practices, situations, and policies that could result in the risk of harm to individuals receiving services. The risk assessment review shall address (i) the environment of care; (ii) clinical assessment or reassessment processes; (iii) staff competence and adequacy of staffing; (iv) use of high risk procedures, including seclusion and restraint; and (v) a review of serious incidents. This process shall incorporate uniform risk triggers and thresholds as defined by the department. (12VAC35-105-520. Risk Management)

The provider shall develop and implement a quality improvement program sufficient to identify, monitor, and evaluate clinical and service quality and effectiveness on a systematic and ongoing basis. The program shall (i) include a quality improvement plan that is reviewed and updated at least annually; (ii) establish measurable goals and objectives; (iii) include and report on statewide performance measures, if applicable, as required by DBHDS; (iv) utilize standard quality improvement tools, including root cause analysis; (v) implement a process to regularly evaluate progress toward meeting established goals and objectives; and (vi) incorporate any corrective action plans pursuant to 12VAC35-105-170. (12VAC35-105-620. Monitoring and Evaluating Service Quality)

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

- As additional data elements are identified and/or developed, it will be important for Commonwealth staff to focus on measurability and definitions of terms, as needed. For example, as the Commonwealth works with the MCOs to develop a common health risk assessment tool, it will be essential to agree upon identical criteria for risk ratings, and ensure that definitions of terms are agreed upon as well.
- The Settlement Agreement provides an inclusive definition of harm (i.e., “Harm includes any physical injury, whether caused by abuse, neglect, or accidental causes”). The Commonwealth’s framework has the potential to encompass a wide variety of harm and risk of harm. As the Commonwealth staff continue to add detail to the framework, they should take care to ensure that it covers the wide breadth of potential areas of harm. As one example, the RMRC minutes reflect considerable focus on decubitus/pressure ulcers, which is an important priority. Minutes reflect the Committee’s recognition that other risks (e.g., aspiration pneumonia, constipation/bowel obstruction, etc.), also require attention, the Committee documented little progress, if any, though, in addressing these other risks of harm.
- Along these same lines, the Mortality Review Committee identified eight conditions that uniquely contribute to the deaths of individuals with ID/DD (i.e., urinary tract infection, constipation/bowel obstruction, aspiration pneumonia, decubitus ulcers, sepsis, seizures, falls, and dehydration). As Commonwealth staff recognize, the early indicators of these conditions should be included in individuals’ ISPs, and incorporated into the triggers and thresholds providers and CSBs track for individuals with ID/DD. Highly sensitive “triggers” should be included for individuals who are older (i.e., over age 45) and who are considered medically complex based on their Support Intensity Scale (SIS) assessments.
- The Commonwealth should consider specifically identifying triggers or thresholds that identify deficits in staff skills or knowledge, or in residential provider support systems. Often, these are the factors that put individuals most at risk. (One example would be neglect findings that illustrate repeated failures on staff’s part to meet individuals’ needs.)
- The Commonwealth should ensure that it addresses quality in the health risk assessment and planning processes as part of its risk management model. For example, it will be important for the Commonwealth to determine whether individuals have risk-reduction plans, but also whether the plans include the basic elements of a quality risk-reduction plans (i.e., provide a clinically relevant and achievable goal by which to measure an individual’s progress or lack thereof, include actions steps sufficient to minimize to the extent possible the individual’s risk, and provide mechanisms to monitor the implementation of the plan), and whether staff are competent in this element of an individual’s services.
- Although annual health risk assessment is an important place to start, a proactive system also will require mechanisms to identify and respond to individuals’ changes of status. For example, CSBs and providers’ risk management systems should be sensitive enough to identify changes in status, such as excessive weight loss and/or gain, or increases in, for example, falls, swallowing issues, seizures, both minor and serious injuries, emesis, pneumonia, behaviors placing the individual at risk, etc.
- It is positive that the Commonwealth effectuated changes to licensing regulations to require providers to fully implement risk management systems, and provide the Commonwealth with necessary and reliable data. Although the adequacy of provider funding is outside the scope of this study, CSBs and providers expressed the need for additional funding to support the implementation of comprehensive quality and risk management systems.
- As noted in previous Reports, it will be important for the Commonwealth to identify mechanisms to gather data from providers that DBHDS does not license to provide IDD services, including nursing homes, private Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IIDs), and private homes.

- DBHDS should consider developing and disseminating criteria for the requirements of a risk management system. In addition to addressing CSBs' and providers' concerns about expectations, specific criteria are needed to allow the Commonwealth to effectively and consistently monitor providers' and CSBs' implementation.
- As has been discussed in previous Reports, moving forward, the Commonwealth should offer classroom training on risk management systems, as well as online training, including the equivalent of experiential-based learning, such as role-plays and discussion.

In summary, since the last Review, the Commonwealth continued to develop a multi-pronged approach to tracking and responding to risk triggers and thresholds. This effort includes a planned component that incorporates CSB and providers' risk management systems. Over the last year, Commonwealth staff took some steps to flesh out its Draft Community-Based Risk Management Framework. However, as indicated in the last Report, once finalized, a number of factors will determine its success, including: the details of the system, which remain under development; training and technical assistance for CSBs and providers; consistent implementation across providers, which have varying levels of understanding and capacity to implement risk management systems; the Commonwealth's oversight of CSBs and providers; as well as the Commonwealth's effective use of the data generated from a number of sources. Commonwealth staff recognize that they have considerably more to accomplish in order to implement and effectively address these requirements of the Settlement Agreement.

V.D.1-6

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

- a. *Safety and freedom from harm (e.g., neglect and abuse, injuries, use of seclusion or restraints, deaths, effectiveness of corrective actions, licensing violations);*
 - b. *Physical, mental, and behavioral health and wellbeing (e.g., access to medical care (including preventative care), timeliness and adequacy of interventions (particularly in response to changes in status);*
 - c. *Avoiding crises (e.g., use of crisis services, admissions to emergency rooms or hospitals, admissions to Training Centers or other congregate settings, contact with criminal justice system);*
 - d. *Stability (e.g., maintenance of chosen living arrangement, change in providers, work/other day program stability);*
 - e. *Choice and self-determination (e.g., service plans developed through person-centered planning process, choice of services and providers, individualized goals, self-direction of services);*
 - f. *Community inclusion (e.g., community activities, integrated work opportunities, integrated living options, educational opportunities, relationships with non-paid individuals);*
 - g. *Access to services (e.g., waitlists, outreach efforts, identified barriers, service gaps and delays, adaptive equipment, transportation, availability of services geographically, cultural and linguistic competency); and*
 - h. *Provider capacity (e.g., caseloads, training, staff turnover, provider competency)...*
4. *The Commonwealth shall collect and analyze data from available sources, including, the risk management system described in Section V.C. above, those sources described in Sections V.E-G and I below (e.g., providers, case managers, Quality Service Reviews, and licensing), Quality Management Reviews, the crisis system, service and discharge plans from the Training Centers, service plans for individuals receiving waiver services, Regional Support Teams, and CIMs.*
 5. *The Commonwealth shall implement Regional Quality Councils that shall be responsible for assessing relevant data, identifying trends, and recommending responsive actions in their respective Regions of the Commonwealth.*
 - a. *The Councils shall include individuals experienced in data analysis, residential and other providers, CSBs, individuals receiving services, and families, and may include other relevant stakeholders.*
 - b. *Each Council shall meet on a quarterly basis to share regional data, trends, and monitoring efforts and plan and recommend regional quality improvement initiatives. The work of the Regional Quality Councils shall be directed by a DBHDS quality improvement committee.*
 6. *At least annually, the Commonwealth shall report publicly, through new or existing mechanisms, on the availability (including the number of people served in each type of service described in this Agreement) and quality of supports and services in the community and gaps in services, and shall make recommendations for improvements.*

The fact-finding for this Report was designed to:

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

- e) Obtain updates on the status of the **Regional Quality Councils (RQCs)** (i.e., Section V.D.5a. and b) and the status of assessments of relevant data, review of trends, and recommendations by the Quality Councils; and
- f) Obtain updates on the Commonwealth website designed to report publicly on the availability, quality, and gaps in services, and recommendations made for improvement (i.e., Section V.6).

Section V.D.1: In response to the Consultant’s request for “Updates, if any, to DBHDS Quality Management Plan,” the Commonwealth did not provide a specific document. However, in the minutes for the 7/12/18 QIC meeting, the Consultant found a reference to an attached document entitled: “DRAFT Virginia Department of Behavioral Health and Developmental Services (DBHDS) Quality Management Program,” dated July 2018. Similar to the DBHDS Quality Management Plan, updated 10/20/16, which the Consultants discussed in the last Quality Report, the July 2018 draft presented a high-level description of how the agency structured its Quality Management program. The document only briefly mentioned the Center for Medicare and Medicaid (CMS) Waiver assurances in the context of DBHDS using the related data to determine its compliance with external requirements. Given the changes the Commissioner made in August 2018, DBHDS will likely need to modify this plan to reflect the recent changes in the administrative structure and redistribution of responsibilities for conducting quality improvement activities.

In addition, the draft document provided a description of the program, and, as such, did not provide a plan or roadmap for DBHDS to expand and improve its ability to collect and analyze data to measure improvement in either the quantity or quality of its services for individuals in the target population. As in the last Quality Report, the Consultant recommends that DBHDS consider incorporating a roadmap (e.g., annual plan) as an attachment to the Quality Management Program and assure that the plan is kept up-to-date to reflect its most current plans and initiatives.

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

Based on interviews with Commonwealth staff, efforts continue to harness some of the data available. The staff within the Data Quality and Visualization Office act as liaisons with the Data Warehouse staff. One example of these efforts relates to making licensing information available more expediently (e.g., provider demographic data) to internal departments, as well as external audiences. Similarly, the Commonwealth is working with Virginia Commonwealth University and Qlarent (i.e., the contractor responsible for the completion of quality service reviews) to make some of the data they collect more accessible and user-friendly.

As discussed in the last Quality Report, DBHDS’s current efforts to identify, analyze and expand the use of data are appropriate first steps. However, based on documentation submitted, DBHDS has not yet developed a structured plan that includes specific goals, objectives, tasks and timelines to guide the efforts necessary to identify, define, collect, analyze, report, and effectively use relevant data to evaluate and improve services. Without a formal plan to establish the parameters, objectives, and timelines for the project, it is difficult to determine, whether externally or internally, if the efforts and resources DBHDS has dedicated to this initiative are making meaningful progress. It is recommended that DBHDS formulate a written plan that captures current and future goals, objectives, and timelines to expand and improve effective use of data, and maintain it as an attachment to the DBHDS Quality Management Program document. Reporting on the status of goal, objective, and milestone achievement should then flow from this plan.

Section V.D.3: Since the last review, the Commonwealth made limited progress with regard to the development of the data-based report to measure progress in each of eight domains set out in Section V.D.3 of the Settlement Agreement. In the last Quality Report, the Consultants summarized the action Commonwealth staff had taken so far. At that time, DBHDS recently implemented a new structure to more effectively group and evaluate the various data indicators under each domain. These more broadly defined categories were characterized as Key Performance Areas (KPA's). In the last Quality Report, the table below described the structure of KPA's and sub-category Domain areas currently used in this revised organizational structure, although DBHDS indicated this was a work in progress that would understandably change with experience:

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

As described in the previous Quality Report, initially, the Data Quality and Analytics Director worked closely with a group of subject matter experts to develop initial measures for each of the

eight domains. DBHDS staff reported that this process helped subject matter experts to gain an understanding of the development of valid and reliable measures with the assistance of data experts.

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

Since the last review, based on review of QIC meeting minutes:

- Minutes showed evidence that since January 2018, the QIC reviewed data from some of the reports listed in the chart above. For example:
 - The minutes for the 2/1/18 meeting described the Committee’s review of data related to independent housing options. The presentation of the data appeared helpful in illustrating the current overall status and progress over time. From the minutes, it appeared some inquiry/analysis was ongoing to determine why some regions made fewer referrals to public housing authorities than others, for example.
 - The minutes for the 3/1/18 meeting described the Committee’s review of provider capacity data. The related presentations showed some helpful illustrations of some of the available data. The presentation ended with the identification of some gaps in services and discussion of some of the next steps.
- For a number of months, however, DBHDS’ development of additional measures for the eight domains appeared to have stalled. During the 4/5/18 QIC meeting, the current Assistant Commissioner for Licensing and Compliance reminded the members that “the Eight Domains Workgroup... recommended that the next step was for the development of specific goals and objectives in each Key Performance Area and domain ... The next step is for subject matter experts to make recommendations on two to three goals for each of the four Key Performance Areas. The recommendations will be brought to the Quality Improvement Committee.”
- During the 7/12/18 QIC meeting, the Director of the Office of Data Quality and Visualization presented draft goals for integrated setting/community inclusion. She reviewed a structure for developing/memorializing outcomes, target objectives, performance measures, data sources, responsible departments, and frequency of reporting. She also reviewed definitions for each of these elements.

The minute noted: “A lot of work needs to be done to ensure we establish what needs to be measured. This will result in more accurate, trended data over time. The role of the KPA subcommittee members is critical including ownership of remediation efforts for what would be needed if goals/outcomes/target objectives are not achieved.” The Assistant Commissioner noted that “all KPA Subcommittees will strive to meet and have draft KPA goals for QIC validation in September.”

- For the 9/6/18 meeting, the draft minutes describe this as: “a continuation of work that had previously been done on the eight domains. While there were reports in each of those areas, the intent was to establish measurable goals for each of the Key Performance Areas (KPAs).”

During this meeting, QIC members received draft measures for a portion of the eight domains: health and well-being, community inclusion, and provider capacity. The minutes documented limited discussion amongst the QIC members regarding the usability of the template, and/or the quality of the draft measures (i.e., validity and reliability).

- With regard to the template (which as discussed above, included outcomes, target objectives, performance measures, data sources, responsible departments, and frequency of reporting), DBHDS staff reported that they created it after surveying a sample of other states to determine what they used. Although this format might be workable, the Consultant found some of the terminology confusing, and in reviewing some of the draft measures, it appeared that subcommittees might have struggled as well to utilize the format to develop valid and reliable measures.

DBHDS might consider following another similar format:

Outcome or Output Measure/Indicator	Baseline or Benchmark Measure	Goal	Timeline	Definitions	Methodology for Collecting Reliable Data
<p>A measurable indicator or goal</p> <p>"Outcome measures" focus on what individuals achieve as a result of the services and supports they receive (e.g., they are free from restraint, they are free from abuse, they choose their roommates, they have jobs, they have non-paid friends, they learn new skills, they maintain healthy weights, etc.)</p> <p>"Output measures" focus on what a system provides or the products (e.g., ISPs that meet certain requirements, annual medical exams, timely and complete investigations of allegations of abuse, etc.)</p>	<p>The current baseline, if known (e.g., at the Facility-level, provider-level, state-level, etc.)</p>	<p>The goalpost(s) for where the Facility/state should be within a certain amount of time</p>	<p>The date by which the goal(s) will be met</p>	<p>Definition of terms included in the measure/indicator. Definitions or standards should be provided for any terms that could be interpreted in more than one way.</p>	<p>It is helpful to think through and memorialize the following:</p> <ol style="list-style-type: none"> 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.); Where the data will be maintained (e.g., a specific database); How often and when the data will be pulled/aggregated (e.g., monthly, quarterly, end of month, within first five days of month for preceding month, etc.); What the schedule is for assessing data reliability and who will be responsible for this; What population or subpopulation (e.g., percentage of the population) will be included in the sample (e.g., 100% or some lesser, but valid sample); The standards that will be applied to judge conformance with the measure; Who will be responsible for collecting and/or reporting the data; 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; and Who will be responsible for analyzing the data.

- As written, the draft measures required significant additional work in order to provide the comprehensive set of measures necessary to collect valid and reliable data. At the time of the Consultant’s review, the QIC had just begun the process of review. Based on their own knowledge and skills, as well as using information from the Consultant’s previous reports, the QIC should complete a thorough vetting process of the measures, and provide feedback, as appropriate to the KPA subcommittees. The following provide just a few examples of problems the Consultant noted:
 - **Prioritization:** In a large system, data are potentially available to measure many outcomes and outputs, and it is unlikely that a system could measure and address all of them well. Therefore, the QIC, with the assistance of the KPA subcommittees, will need to prioritize some over others. Although at the time of the review, the QIC had not yet engaged in a prioritization process, it was not clear how the subcommittees chose some measures over others. For example:
 - An outcome read: “DD providers review medication errors at least quarterly,” and the corresponding target objective was “86% of DD providers that administer medications are not cited for failure to review medication errors at least quarterly.” Although these data are likely easy to obtain from OLS, the measure does not provide information about, for example, the severity of the medication errors that occur, or providers’ efforts to prevent their recurrence.
 - Similarly, an outcome read: “The state demonstrates that an incident management system is in place that effectively resolves incidents and prevents further similar incidents to the extent possible,” and the corresponding target objective was “Providers report critical incidents to the Office of Licensing within the required time frames as specified in the approved waiver.” Timeliness of reporting is only one aspect of an incident management system, albeit important, but it is unclear what other aspects of the outcomes or outputs of the incident management system the Commonwealth intends to measure.
 - **Validity of data:** DBHDS should design outcome and output measures that collect data on what they purport to measure. Although many of the measures require further refinements, it was good to see that most of the targeted objectives provided a measure of at least some component of the identified outcome or output. The following provides an example in which validity was questionable:
 - The outcome read: “Support Coordinator and Support Coordinator supervisory competencies are completed,” and the target objective read: “By - 2019, competencies are available for use by all Support Coordinator agencies.” The objective appeared to be a step in the process, but did not measure whether or not support coordinators and their supervisors successfully completed the competencies.
 - **Reliability of data:** DBHDS should design the data collection methodologies to collect consistent, reproducible data. The draft KPA measures did not define how DBHDS intended to test the reliability of the data (e.g., inter-rater reliability, probes, etc.). In addition, sometimes the draft measures did not define terms, which could impact the reliability of data. For example:
 - A draft outcome read: “Individuals are competitively employed,” and the related measure was “50% of individuals employed work on average 20 hours per week.” Within the draft measures document, the subcommittee had not defined the terms “competitively employed,” and/or “employed.” If such definitions exist, the subcommittee should incorporate them into the document.

Moreover, the subcommittees had not defined the sources for the data, which is an important step in increasing the likelihood of obtaining reliable data. Sometimes, other reports included information about the Commonwealth's efforts to collect reliable data (e.g., for the indicator listed above, the Draft Semi-Annual Report on Employment, dated December 2017, provided additional information about data collection techniques, but again, the subcommittee should make this information evident in the measures document).

- **Baseline measurements:** With few exceptions, DBHDS did not provide baseline measurements. Sometimes this is not possible, but whenever possible, baseline information should be identified to help inform the goal or target and to help determine whether changes occur.
- **Goals/targets:** Most of the draft KPA measures included goals or targets, but it was unclear how the subcommittees made their decisions. In part, without baseline information, many of the targets appeared random. For example:
 - For the outcome that read: "Providers confirm that employees meet minimum standards for employment," the target objective was "86% of licensed provider agency staff have criminal background checks with satisfactory results as specified in policy/regulation." Given the importance of satisfactory background checks, it is unclear how this goal could be less than 100%.

In sum, in previous Quality Reports, the Consultant documented the Commonwealth's efforts to initiate development of measures to allow it to collect and analyze valid and reliable data about individuals receiving services across the eight domains. In each of the previous Reports, the Consultant noted incremental progress. Based on the documentation provided and interview with staff, during the past year, the Commonwealth's efforts stalled for a period of months, and efforts to reinvigorate them occurred in the months prior to this review. The development of valid and reliable measures is time-consuming. However, over the next six months to a year, Commonwealth staff should exert concerted effort to draft, finalize, and begin implementation of a set of measures across the eight domains. In this Report, the Consultant has offered one possible format for memorializing the measures, as well as the methodology for operationalizing data collection and review.

Section V.D.5: Since the last review, the status of the RQCs essentially remains the same. As indicated in the last Quality Report, RQCs are operational and they consistently hold meetings each quarter in each of the five Regions. DBHDS staggered the membership terms for each member to ensure consistency as members' terms expire. Minutes reviewed showed efforts to replace members as vacancies occurred.

RQCs use consistent agendas to guide the structure and discussion of each meeting. Minutes reflect that some discussion items focus specifically on reports based on data (e.g., employment report, housing report). The use of data and related analyses as the primary foci of discussion in these meetings continues to be in its infancy. However, continuing focus on structuring the meetings around data analysis presentations will enhance the capabilities of each RQC to identify trends and to recommend responsive actions to identified issues. This also will improve the ability of each RQC to provide substantive and meaningful response to DBHDS regarding regional impacts of various new initiatives and process changes to improve the service delivery system that DBHDS implements or is considering. The format and content of the meeting minutes is clear

and efficient; however, the minutes continue to reflect considerable variability in identifying specific feedback and recommendations from the regional participants, and at times, the minutes do not reflect that the RQCs offered any recommendations.

As indicated in the last Quality Report, as the use of data continues to evolve, DBHDS should identify data measures/reports that allow comparative presentation of information across its Regions and over time. To be truly effective in meeting both the stated requirements in Section V.D.4 of the agreement and to facilitate use of these meetings as a primary source of Regional review and feedback on service delivery system metrics across the Commonwealth, DBHDS should consider focusing attention in the RQC meetings on a small number of key measures that lend themselves to comparability and measurement over time.

Section V.D.6: At least annually, the Commonwealth is required to report publicly, through new or existing mechanisms, on the availability (including the number of people served in each type of service described in the Agreement) and quality of supports and services in the community and gaps in services, and make recommendations for improvement. In the last Quality Report, the Consultants reported that due to changes with the DBHDS website, reports that the website previously included were deleted. By March 2018, DBHDS anticipated that the annual report would be up and running. At the time of the current review, the website was not yet operational.

The Settlement Advisor to the Commissioner provided a spreadsheet that identified approximately a dozen existing reports ready for upload to a website. It also listed other reports or data for which the Settlement Advisor needed to make further inquiries or other DBHDS staff needed to develop or finalize.

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

In conclusion, since the last Review, although DBHDS staff made some efforts to expand and improve use of data to guide its assessment of necessary service delivery improvements, little substantive progress occurred. It is critical that DBHDS create a comprehensive data quality improvement plan that provides a roadmap and specific milestones to guide its ongoing efforts. Such a plan should include action steps and milestones to expand and improve the quantity and quality of data to measure performance, provide a structure for greater accountability of effort, and assist in appropriate allocation of resources to develop better data reporting systems, better analysis of data and to support the Department's effective use of data in its performance measurement.

V.E.1-3

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

Goals for this Review included to determine whether or not:

- a) DBHDS has established a baseline regarding existing QI practices;
- b) As of April 1, 2018, DBHDS established expectations for providers’ and CSBs’ quality improvement systems (i.e., Section V.E.1);
- c) DBHDS requires providers and CSBs to report on key indicators that address both positive and negative outcomes for health and safety and community integration per Section V.E.2;
- d) DBHDS Quality Improvement Committee has begun to review and to address these measures;
- e) Providers and CSBs have begun implementing root cause analysis, as appropriate, and if so, have implemented action plans to address identified causes that have either resulted in desired outcomes, or if not, have been modified; and
- f) DBHDS is aware of the extent to which providers and CSBs are meeting its expectations.

As noted in the last Report, the Settlement Agreement established the requirement for providers to monitor and to evaluate service quality; it references the DBHDS Licensing Regulations at 12 VAC 35-105-620. As noted above, the Commonwealth modified the regulations, which add substantially to the requirements (underlined passages show additions):

The provider shall develop and implement a quality improvement program sufficient to identify, monitor, and evaluate clinical and service quality and effectiveness on a systematic and ongoing basis. The program shall (i) include a quality improvement plan that is reviewed and updated at least annually; (ii) establish measurable goals and objectives; (iii) include and report on statewide performance measures, if applicable, as required by DBHDS; (iv) utilize standard quality improvement tools, including root cause analysis; (v) implement a process to regularly evaluate progress toward meeting established goals and objectives; and (vi) incorporate any corrective action plans pursuant to 12VAC35-105-170. 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 improvement plan. The provider shall implement improvements, when indicated. (12VAC35-105-620. Monitoring and Evaluating Service Quality)

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

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

In reviewing the results of the survey, Commonwealth staff concluded that most respondents have some form of quality improvement/risk management planning occurring. Although the results provided some insights, DBHDS staff determined that they should conduct another survey with more clearly-stated questions. Based on review of RMRC minutes for the current Review, DBHDS delayed a second survey, pending further development of the QIRM framework.

Since the last review, under the leadership of the Community Quality Management Director, DBHDS quality improvement staff engaged in a significant undertaking to review aspects of all 40 CSBs' data collection and reporting methodologies. The 3/26/18 RQM minutes describe the genesis and goals of this project:

As a follow-up of CM data reporting to the Quality Improvement Committee (QIC) in July 2017, DBHDS formed a workgroup and revised the data measures and extract specifications with anticipated improvement in October/November data. When this did not occur, further analysis indicated issues may be related to coding.

In December 2017, DBHDS decided to review the CSBs internal data to validate data and data reporting processes and provide technical assistance and consultation to CSBs that were not meeting data reporting targets to assist in identifying and resolving data collection and reporting, and facilitate root cause analysis of data reporting with CSB teams (Executive Director, DDS Director, SC Supervisor, QI, IT, etc.)

Based on review of a sample of reports from these reviews, as well as interviews with two CSBs, these efforts were extremely helpful in identifying problems impacting the collection of valid and reliable data, as well as providing technical assistance to resolve identified issues. Such issues included, but were not limited to coding issues, confusion regarding outcome measures, issues with the numerous electronic health records that different CSBs use (i.e., DBHDS staff estimated CSBs

use eight to nine different EHRs with varying capability to run reports), and a need for improvement in Support Coordinators' ability to identify and monitor risks.

The 4/30/18 RMRC minutes explained the follow-up process as:

CSBs are provided with a summary of issues identified and recommendations for quality improvement at the end of each CSB Review. This is followed by the final version of the CSB Review Summary and a request for the CSB to complete a 30/60/90 status update for CSBs to briefly report their progress on the recommended actions.

In addition to identifying issues that CSBs needed to address, this review process also assisted in identifying follow-up actions in which the Commonwealth needed to engage, for example to clarify expectations. As of early July 2018, DBHDS staff completed reviews of all 40 CSBs. Overall, this effort, required a substantial time commitment from DBHDS staff, but appeared beneficial to both DBHDS, the Community Consumer Submission 3 (CCS3) data collection and extract process, as well as the 40 CSBs. Given that follow-up continued, not all issues identified were resolved, but it was encouraging that these efforts were underway.

As discussed above with regard to risk management, DBHDS staff created a draft QIRM framework. The document included extensive information and potential resources that might be helpful to CSBs and other providers in developing or refining their QI programs. As discussed while the Consultant was on site and explained further above, repackaging and providing practical examples of the application of some of this information might make it a more user-friendly tool for CSBs and providers.

As noted in the sections above, since the last Review, the Commonwealth made limited progress in finalizing drafts of the data that it intends to collect. In order to address the requirements of the Settlement Agreement, additional data will be required. In some cases, improvements also are needed in the reliability of the data that are currently being collected. In other cases, mechanisms and methodologies for collecting the data need to be developed.

Based on the Consultant's meetings with a small number of CSBs and private providers, the impressions, albeit limited, gained from these quality improvement staff, were identical to those garnered from the previous two year's reviews, which are summarized again here with a few additions:

- The various CSBs and private providers each allotted different levels of resources to the quality assurance/improvement functions.
- The activities in which the CSB and private provider QI staff were involved varied from making sure basic functions occurred timely and completely, to more advanced quality improvement activities.
- Some of the CSBs had Quality Councils or leadership meetings at which quality improvement information was presented and discussed, information analyzed, and actions taken to effectuate change.
- In discussing the Commonwealth's requests for data, CSB staff cited CHRIS reports as the main data request. Case Management extract data and REACH data also were identified as data they regularly submitted. Staff interviewed generally were unfamiliar with risk triggers and thresholds.
- A common theme for CSBs and providers was that current record-keeping practices (i.e., various EHRs, combinations of paper and electronic systems) presented challenges in terms of easy extraction of specific data points.

- The CSB staff interviewed found the technical assistance DBHDS provided with regard to the CCS3 data collection and reporting process helpful.
- The CSB and provider staff involved were eager to obtain criteria further defining the Commonwealth's expectations for meeting the revised regulatory requirements for quality assurance/improvement programs.
- A regular concern that CSBs and other providers cited was not having the funding necessary to fully implement a comprehensive risk management and quality improvement program.

The Commonwealth's Quality Improvement Committee continues to meet at least quarterly (i.e., 1/11/18, 2/1/18, 3/1/18, 4/5/18, 7/12/18, and 9/6/18). Based on interviews with DBHDS staff as well as review of recent meeting minutes and Draft QIC Operating Procedures, dated July 2018, DBHDS staff identified concerns related to membership, attendance, as well as the content of the meetings. Some of the current considerations included:

- With regard to attendance, consistency was needed. Often alternate members attended, which made it difficult to move forward efficiently with members who had the necessary knowledge and information.
- With regard to the Committee's membership, staff recognized the need for members with both programmatic/clinical knowledge, as well as knowledge about data and analysis techniques. Leadership was also considering involving community CSB/provider members, family and individual members, as well as staff from other agencies.
- As discussed above, the Committee had reinvigorated the process of defining measures related to the eight domains.

Based on the Consultant's review of recent minutes, DBHDS' efforts to make modifications are warranted. Although some positive activity occurred under the leadership of the QIC, such as the Support Coordination/Case Management QI project discussed above, the QIC was not yet a data-driven oversight and decision-making body.

As recommended in the last Report, to advance its efforts to establish meaningful data measures of its service delivery system, DBHDS should exert considerable effort along a planned path. It should clearly define each data element, and it should ensure both that each data element is an objective measure and that an electronic data reporting system exists that will allow providers to consistently, and accurately report data without taking excessive staff time and effort.

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

V.H.1-2

- 1. The Commonwealth shall have a statewide core competency-based training curriculum for all staff who provide services under this Agreement. The training shall include person-centered practices, community integration and self-determination awareness, and required elements of service training.*
- 2. The Commonwealth shall ensure that the statewide training program includes adequate coaching and supervision of staff trainees. Coaches and supervisors must have demonstrated competency in providing the service they are coaching and supervising.*

Note: Additionally, other sections of the Settlement Agreement establish requirements relating to staff training. Other consultants of the Independent Reviewer address these components of the Settlement Agreement, so they are not the focus of this report.

The goal for this Review was to determine the status of the Commonwealth's planning, development, and implementation of training initiatives to achieve compliance with the expectations of the Settlement Agreement (Section V.H) (i.e. competency-based training on person-centered practices, community integration and self-determination awareness, and required elements of service, and of adequate coaching and supervision of staff trainees).

As discussed in the last Report, the training curricula DBHDS developed included the following competencies:

- Virginia's Competencies for Direct Support Professionals (DSP) and Supervisors Who Support Individuals with Developmental Disabilities, revised 11/28/16. In response to stakeholder feedback, DBHDS staff streamlined these competencies, and on 9/25/17, reissued these competencies, dated 9/1/17;
- Virginia's Health Competencies for Direct Support Professionals and Supervisors Who Support Individuals with Developmental Disabilities, revised 1/19/17;
- Virginia's Behavioral Competencies for Direct Support Professionals and Supervisors Who Support Individuals with Developmental Disabilities, revised 9/1/17; and
- Virginia's Autism Competencies for Direct Support Professionals and Supervisors Who Support Individuals with Developmental Disabilities, revised 9/1/17.

In her last review of Training, this Consultant recommended that DBHDS continue to focus its attention on simplifying and streamlining its requirements for providers as this was a consistent issue identified through provider interviews for that study. For the current review, DBHDS submitted a document entitled Draft DSP Competencies Checklist Template, revised 8/28/18. Based on interview with the Director of Provider Development, DBHDS' goals were to simplify the competencies to identify the basic requirements that all DSPs should demonstrate, as well as to make them more measurable. The intent was for these revised competencies to eventually replace the Virginia's Competencies for Direct Support Professionals (DSP) and Supervisors Who Support Individuals with Developmental Disabilities, revised 9/1/17.

Based on a comparison between the draft document and the previous version, these changes would:

- Maintain the three overall competencies:
 - Demonstrating person-centered skills, values, and attributes;
 - Understanding and following service requirements; and
 - Demonstrating abilities that improve or maintain the health and wellness of those they support.
- Reduce the number of specific competencies/skills/abilities necessary to meet the three overall competencies from 48 to 17;
- Add observation indicators that provide more description of the types of observable actions or activities in which DSPs should engage in order to demonstrate that they mastered the expected competency; and
- Allow supervisors the option of documenting a staff member's progress in attaining the specific competency (i.e., basic understanding, developing, competent), but require a final check-off when the staff member demonstrates proficiency, which the tool defines as "individual demonstrates all aspects of the skill or action and on a routine basis in practice as appropriate to the skill or action; minimal supervision needed."

Commonwealth staff indicated that the next steps included obtaining feedback from the Independent Reviewer and Consultant, and obtaining feedback from CSBs and providers at conferences. At one conference that DBHDS staff already attended, providers reportedly offered initial positive feedback with regard to the changes. Based on feedback on this draft document, the Commonwealth intended to revise the other three competency checklists in a similar manner.

Overall, the changes represent positive steps forward. In response to the recommendations in the last report, the revised competencies are simpler and somewhat more measurable, making it more likely that CSBs and other providers will implement them fully and more consistently. The Consultant offers the following more specific comments:

- Although it appears that DBHDS used a thoughtful decision-making process in reducing the number of specific competencies/skills/abilities to address the overall competencies from 48 to 17, the list lost some important competencies/concepts in the process. In addition to those the draft covers, DBHDS should consider adding the following competencies/skills/abilities to the specific overall competencies:
 - Demonstrating person-centered skills, values, and attributes should also include:
 - Using person-first language;
 - Recognizing behavior as a form of communicating choice; and
 - Involving individuals in choices throughout their days;
 - Understanding and following service requirements should also include:
 - For supervisors, providing DSPs with guidance or taking remedial action to the extent necessary to ensure: a) provision of services; and b) necessary documentation; and
 - Demonstrating abilities that improve or maintain the health and wellness of those they support should also include:
 - Adhering to privacy requirements;
 - Accurately recording health data/information (e.g., seizures, falls, bowel movements, intake/output, etc.);
 - Implementing health/behavioral health care support plans as written;
 - Maintaining a safe environment; and
 - Adhering to safety procedures (e.g., evacuation procedures).

- Some measurability issues still exist. It is important to resolve these issues, because as discussed in the last Training Report, lack of measurability negatively impacts both providers' ability to consistently ensure their staff have the necessary competencies, as well as DMAS and DBHDS Office of Licensing staff's ability to reliably measure providers' compliance with, and otherwise hold providers accountable to fulfilling the requirements. Based on interviews with CSBs and providers, most expressed continuing concern about whether their training and their determinations that staff have demonstrated competence will comport with external monitors' expectations. Some examples of measurability include:
 - Some competencies continued to measure more than one skill [e.g., "Supports individuals to locate and participate in community activities that reflect the individual's personal preferences and assures they are safe and accessible for them" (emphasis added)].
 - Similarly, the following competency addresses timeliness as well as accuracy of data, and also implies that staff show competency in completing a wide variety of types of documentation: "Maintains state and agency required documentation and data collection that is timely, accurate, and factual" (emphasis added). The observation/indicator reads: "Writes a signed, dated note that meets Medicaid requirements by including the support provided, person's response to the support, and any additional information needed." So, in other words, this competency measures whether the documentation is timely, and whether it is accurate (it is unclear the difference between accurate and factual). In addition, it is unclear whether a DSP would meet the competency when he/she shows the ability to write this one type of note, or if the competency is intended to measure the quality of many different types of documentation (e.g., behavioral data, incident information, skill acquisition data, health-related data).
- The observation indicators generally move the competency checklist in the direction of providing operational/functional descriptions of actions or activities in which DSPs and/or their supervisors could engage that would show they mastered demonstration of the competency. However, more work is needed. DBHDS staff should consider:
 - Most of the observation indicators appear to provide examples as opposed to more complete lists. For example:
 - For the competency: "Facilitates interactions with others in natural settings with persons without disabilities (other than those paid to support the individual)," the observation indicator reads: "Demonstrates including individuals in introductions and conversations as would occur in community settings." To demonstrate this competency, staff could engage in a number of other activities, such as assisting an individual to make purchases, order at a restaurant, participate in a sporting event or a volunteer opportunity involving peers, interact with a neighbor, etc. The draft does not clarify if other such actions or activities would qualify.
 - For the competency: "Locates health information in the individuals' records and understands, at least at a basic level, its meaning and how it affects the individual they support and the care they must provide" (emphasis added), the observation indicator reads: "Describes the identified health and behavioral health support needs for each individual and their role in providing support to each person." This competency measures more than one skill, and includes a difficult to measure concept: "understands." The observation indicator only includes staff verbally describing individuals' needs, when a functional definition of competency might also include, for example, a DSP implementing health support plans as written, notifying nurses or other healthcare professionals as needed and as defined in health plans, reporting side effects of medications, etc.

The Commonwealth should consider: a) specifying whether or not each DSP needs to demonstrate each of the items listed; b) expanding the lists of options for many of the observation indicators to assist in better defining the competencies/skills/abilities; and c)

- specifying whether or not it will allow a CSB or other provider to identify other observation indicators if they reasonably demonstrate mastery of the competency/skill/ability.
 - Bulleted lists of discreet activities or actions with check boxes might allow an easy mechanism for supervisors to track their observations.
- Based on review of the revised document, the level of evidence that DBHDS is requiring CSBs and other providers to maintain to document each DSP's proficiency with a competency/skill/ability is a check-mark in the "proficiency confirmed" column. Based on interviews with CSBs and providers, they use various methods to maintain this information, including paper, spreadsheets, and/or more sophisticated databases. DBHDS should consider including space for supervisors to document a date on which the staff member demonstrated the skill. In addition, it is unclear how a checkmark provides sufficient evidence of competence. The Independent Reviewer's studies have found many examples of boxes being checked without the task having been completed. For example, DBHDS could include space for a supervisor to write in observations that provide evidence of competency. If DBHDS expands the observation indicators as discussed above, room for supervisors to note the date or specifics about their observations would offer another option. Such options might provide more robust documentation showing that staff have achieved proficiency with a particular competency/skill/ability or service element (i.e., implementing an individual's fall prevention protocol).

With regard to requirements for CSBs and other providers to implement training:

- The last Training Report described emergency regulations that provided an initial mechanism for review and enforcement, if necessary, of providers' adherence to the training requirements. Emergency regulations (i.e., 12VAC30-120-515) related to the Waiver implementation, which were in effect from 9/1/16 through 2/28/18, set forth detailed requirements for competency-based training. It appeared that these regulations were extended.
- Since the last Training Report, the Commonwealth issued the Rules and Regulations for Licensing Providers by the Department of Behavioral Health and Developmental Services (Chapter 105). These regulations provide much less specific requirements that state:
 - The provider shall provide training and development opportunities for employees to enable them to support the individuals receiving services and to carry out their job responsibilities. The provider shall develop a training policy that addresses the frequency of retraining on serious incident reporting, medication administration, behavior intervention, emergency preparedness, and infection control, to include flu epidemics. Employee participation in training and development opportunities shall be documented and accessible to the department.
- Given that Commonwealth staff indicated that licensing reviews would be a primary way to assess providers' compliance with its training requirements, it will be important to resolve discrepancies between the various regulations, and define clear expectations with regard to competency-based training.

Providers and CSBs with whom the Consultant spoke consistently expressed concern that they do not receive feedback regarding whether or not their training meets the Commonwealth's requirements. They indicated that the competencies require them to maintain voluminous documentation, which is time consuming, but they remain uncertain that they have complied with the Commonwealth's expectations.

As the full implementation of the revised training competencies and supervisory coaching matures, the Department must develop mechanisms for determining whether CSBs and providers are implementing the competency-based training, whether the training results in staff being able to

demonstrate competence, and whether the competencies developed are having the intended impact. As of this review, DBHDS had not formalized such mechanisms.

As indicated in the last Training Report, the Commonwealth planned for the Office of Licensing Services, DMAS, and the DBHDS Quality and Risk Management Division to assess various components of CSB and provider training. This will require DBHDS to develop specific data indicators and measurement criteria to facilitate consistent implementation and reliable reporting. Such measures will also support the Commonwealth's ability to hold all CSBs and private providers to the same standards and ensure a consistent level of competency across staff throughout the system. Given the complexity of the provider system across the Commonwealth, the Consultants suggested that the Commonwealth identify a small number of measurable data indicators related to training that are common to each provider location and work within that framework to develop reporting mechanisms that each provider is capable of supporting. Some examples of measurable data indicators could include: 1) the number and percent of newly hired staff who completed initial training required by DBHDS within 30 days of employment; 2) the number and percent of staff who have *demonstrated* ability to operate adaptive and orthopedic equipment safely, etc. As these initial measurable data indicators are rolled out and deemed successful, more measures can be incrementally added leveraging processes and lessons learned from the initial work.

The following additional issues the Consultant raised in the last Training support continue to require attention:

- The Virginia's Competencies for Direct Support Professionals and Supervisors Who Support Individuals with Developmental Disabilities, revised 11/28/16, and Virginia's Health Competencies for Direct Support Professionals and Supervisors Who Support Individuals with Developmental Disabilities, dated 6/10/16 and revised 1/19/17, included a number of basic competencies related to individuals' health and wellness, which represented an improvement. However, additional competencies would be necessary for staff to fully support delivery of the individualized service elements for individuals with complex medical and/or behavioral needs, including direct support professionals and nurses.

Based on interviews with CSB and other provider staff for this review, DBHDS should seek input from them in revising these training requirements. Some providers reported already having training modules for staff supporting individuals with complex medical needs, which might be helpful in the revision process.

- Regarding training to address elements of needed service as described in individuals' ISPs, requirements were nebulous. Feedback obtained through interview of CSB and provider staff indicated that some, but not all established additional competencies that might be necessary to implement individualized components of service plans that are not covered through the competencies the Commonwealth specifically required.

In summary, since the last review, DBHDS staff drafted revised direct support professional and supervisory competencies, which addressed the need to streamline the original competencies. However, work was needed to refine the revised draft. The Commonwealth continues to need to develop methodologies for determining whether CSBs and providers are implementing the competency-based training, whether the training results in staff being able to demonstrate competence, and whether the competencies developed are having the intended impact.

APPENDIX A – Interviews and Documents Reviewed

Interviews:

- Hughes Melton, MD, Commissioner of DBHDS
- Dev Nair, DBHDS, Assistant Commissioner for Licensing and Compliance
- Alexis Aplasca, MD, Chief Clinical Officer
- Peggy Balak, Settlement Advisor to the Commissioner
- Jodi Kuhn, Director, Office of Data Quality and Visualization
- Eric Williams, Director of Provider Development
- Challis Smith, Community Quality Management Director
- Cathy Starling, Quality Improvement Program Specialist
- Debra Vought, Quality Improvement Program Specialist
- QI and Training staff from:
 - Loudon County CSB
 - Prince William CSB
 - NOVA Family Services
 - The Arc of Greater Prince William County

Documents Reviewed:

- DBHDS Organizational Structure, dated 8/24/18
- QIC meeting agendas, handouts and minutes for meetings on 1/11/18, 2/1/18, 3/1/18, 4/5/18, and 7/12/18, and draft minutes for 9/6/18
- CSB Case Management Quality Reviews for the following CSBs: Crossroads, Danville Pittsylvania, District 19, Highlands, Loudon, and Prince William
- Chapter 105, Rules and Regulations for Licensing Providers by DBHDS
- Person-Centered Practices ISP Modules 1 through 4
- Draft Virginia’s Competencies for Direct Support Professionals and Supervisors who Support Individuals with Developmental Disabilities, dated 8/28/18
- 2018 Person-Centered ISP Guidance, dated 6/15/18
- Person-Centered Plan Development PowerPoint presentation, September 2018
- ISP WaMS Part I-IV Sample, Part V Residential Sample, Part V SN Modified Use Sample, and Part V CE Sample
- Part V Support Instructions Residential Sample
- Part V Plan for Supports SN Sample
- RMRC minutes, dated 10/26/17, 11/28/17, 12/19/17, 1/30/18, 2/20/18, 3/26/18, 4/30/18, 5/29/18, 6/25/18, and 7/30/18
- Draft Resource Tool to Develop a Provider Quality Improvement/Risk Management (QIRM) Framework; and draft minutes, dated 8/27/18
- Commonwealth Coordinated Care Plus MCO Contract January 2018: Excerpts Related to Health Risk Assessments
- Risk Management Test Report
- RQC meeting agendas, handouts and minutes for Quarters 2, 3, and 4, FY18
- V.D.6 Project spreadsheet, dated 8/23/18

APPENDIX I.
LIST OF ACRONYMS

APS	Adult Protective Services
AR	Authorized Representative
AT	Assistive Technology
BCBA	Board Certified Behavior Analyst
BSP	Behavior Support Professional
CAP	Corrective Action Plan
CEPP	Crisis Education and Prevention Plan
CHRIS	Computerized Human Rights Information System
CIL	Center for Independent Living
CIM	Community Integration Manager
CIT	Crisis Intervention Training
CL	Community Living (HCBS Waiver)
CM	Case Manager
CMS	Center for Medicaid and Medicare Services
CPS	Child Protective Services
CRC	Community Resource Consultant
CSB	Community Services Board
CSB ES	Community Services Board Emergency Services
CTH	Crisis Therapeutic Home
CTT	Community Transition Team
CVTC	Central Virginia Training Center
DARS	Department of Rehabilitation and Aging Services
DBHDS	Department of Behavioral Health and Developmental Services
DD	Developmental Disabilities
DDS	Division of Developmental Services, DBHDS
DMAS	Department of Medical Assistance Services
DOJ	Department of Justice, United States
DS	Day Support Services
DSP	Direct Support Professional
DSS	Department of Social Services
ECM	Enhanced Case Management
EDCD	Elderly or Disabled with Consumer Directed Services
EFAG	Employment First Advisory Group
EPSDT	Early and Periodic Screening Diagnosis and Treatment
ES	Emergency Services (at the CSBs)
ESO	Employment Service Organization
FRC	Family Resource Consultant
GH	Group Home
GSE	Group Supported Employment
HCBS	Home- and Community-Based Services
HPR	Health Planning Region
HR/OHR	Office of Human Rights
HSN	Health Services Network
ICF	Intermediate Care Facility

ID	Intellectual Disabilities
IDD	Intellectual Disabilities/Developmental Disabilities
IFDDS	Individual and Family Developmental Disabilities Supports (“DD” waiver)
IFSP	Individual and Family Support Program
IR	Independent Reviewer
ISE	Individual Supported Employment
ISP	Individual Supports Plan
ISR	Individual Services Review
LIHTC	Low Income Housing Tax Credit
MLMC	My Life My Community (website)
MOU	Memorandum of Understanding
MRC	Mortality Review Committee
NVTC	Northern Virginia Training Center
ODS	Office of Developmental Services
OHR	Office of Human Rights
OIH	Office of Integrated Health
OL	Office of Licensing
PASSR	Preadmission Screening and Resident Review
PCR	Person Centered Review
PCP	Primary Care Physician
POC	Plan of Care
PMM	Post-Move Monitoring
PST	Personal Support Team
QAR	Quality Assurance Review
QI	Quality Improvement
QIC	Quality Improvement Committee
QMD	Quality Management Division
QMR	Quality Management Review
QRT	Quality Review Team
QSR	Quality Service Review
RAC	Regional Advisory Council for REACH
REACH	Regional Education, Assessment, Crisis Services, Habilitation
RFP	Request For Proposals
RNCC	RN Care Consultants
RST	Regional Support Team
RQC	Regional Quality Council
SA	Settlement Agreement US v. VA 3:12 CV 059
SC	Support Coordinator
SELN AG	Supported Employment Leadership Network, Advisory Group
SEVTC	Southeastern Virginia Training Center
SIS	Supports Intensity Scale
SW	Sheltered Work
SRH	Sponsored Residential Home
START	Systemic Therapeutic Assessment Respite and Treatment
SVTC	Southside Virginia Training Center
SWVTC	Southwestern Virginia Training Center
TC	Training Center
VCU	Virginia Commonwealth University