- integrated day activities and supported employment;
- subsidized community living options; and
- an individual support planning process focused on helping individuals to learn new skills in order to become more self-sufficient.

The Commonwealth has continued efforts to achieve compliance in most of theses areas. Despite these efforts, the IR determined that the Commonwealth has not yet met these requirements. The Commonwealth has not implemented initiatives sufficiently to substantively impact the members of the target population. With the Commonwealth's delay both in implementing its redesigned HCBS waiver and in providing housing resources, it remains in non-compliance and will remain in non-compliance until it implements needed systems reforms.

The Quality and Risk Management provisions (i.e. Quality provisions) comprise a substantial portion of the number and complexity of the Agreement's requirements. These provisions are designed with the goal of ensuring that all services are of good quality, meet individuals' needs, and help individuals achieve positive outcomes. The Parties recognized that implementation of these provisions would involve building a statewide system that operates with multiple levels, variables, and sources of input. Although components of a Quality system had existed, the Agreement recognized that what existed fell far short of what should be established. When the Agreement was approved, the Commonwealth had an inadequate organizational infrastructure and insufficient human resources to design, build and operate a statewide operating Quality and Risk Management system. All stakeholders want the Commonwealth to have achieved by now the goals of the Quality provisions, but this is an enormous and complex undertaking. The Commonwealth has now added leadership and staff and has implemented the structural components of a Quality system. It is now creating the organization processes and performance expectations needed to effectively implement a statewide Quality system. The Parties did not agree on due dates; many of the provisions in this section do not have them. The IR prioritized monitoring the Quality provisions during the previous review period. The Commonwealth was in non-compliance with most of these provisions at that time. The IR decided not to prioritize monitoring these provisions during this current period. The four month period since the IR's December 6, 2014 Report and the April 6, 2015 end of the current review period was too brief to accomplish substantial systemic change. Updated compliance ratings are deferred until the next review period when the IR will prioritize monitoring the Quality provisions.

This report also does not include updated ratings of compliance for most Discharge Planning and Transition provisions. The IR prioritized monitoring these provisions in the previous Report to the Court. At that time, the IR determined that the Commonwealth had achieved compliance with twenty-four of the thirty-three requirements. The IR has determined that the substantial changes needed to achieve compliance ratings in most remaining areas would require more than one review period. Therefore, updated compliance ratings are deferred until the next review period when the IR will prioritize monitoring the Discharge Planning and Transition provisions.

Under the Agreement, the Commonwealth has created 2005 HCBS waiver slots, 200 more than the minimum required. These waiver slots allowed individuals with ID and DD, most of whom had been on waitlists for many years, to receive HCBS waiver-funded services. The IR found that receiving these services has significantly improved the quality of life for these individuals and their families. Between October 11, 2011 and April 30, 2015, the Commonwealth has assisted 443 individuals to transition from the Training Centers to more integrated community-based settings. The IR's studies of more than 100 of these individuals' services found that, although there were

Of the twenty-five randomly selected individuals, nine (36%) lived in Region 1 (NW Virginia), sixteen (64%) live in Region V (Tidewater). Overall, these randomly selected individuals with DD, other than ID whose services the IR studied during the sixth review period differed from the group of individuals who moved from Training Centers whose services were studied during the fifth review period:

Demographic information	**Twenty-eight (28) individuals who moved from Training Centers** **5th period study**	**Twenty-five (25) individuals with DD, other than ID,** **6th period study**
Gender	13 (46.4%) were males	16 (64%) were males
Age Ranges	22 (78.5%) were age fifty one or older	20 (80%) were age thirty or younger
Levels of Mobility	11 (39.3%) use wheelchairs	19 (76%) were ambulatory without support
Highest Level of Communication	18 (64.3%) use gestures	20 (80%) fully articulate without assistance
Type of Residence	26 (92.9%) live in congregate residential programs	23 (92%) live in his or her own or family's home

Many of the individuals with DD, other than ID, were diagnosed with Autism Spectrum Disorders, which is likely the reason for the higher percent of males. The age profile of those selected, and the fact that the IFDDS waiver slots do not offer residential programs, is consistent with the higher percentage of the sample living with their families.

Although there were individual exceptions, the study of services for individuals with DD, other than ID, found the following themes:

a. New waiver services significantly improved the quality of life for individuals with DD, other than ID and their families. The Individual Review teams again found that families demonstrated strengths, often making incredible efforts, while providing loving support for their family members. The level of support required often took physical, emotional, employment and financial tolls on these families. These burdens were eased when a family member provided the staff support to the individual because the family member knew the individual well, understood what providing needed supports involved, and was less likely to resign after a short period of time.

The positive outcomes included that all twenty-five individuals (100%) were receiving case management services; the Individual Support Plans (ISP)/Plans of Care (POC) were current (92%) person-centered (96%), and related to the individuals' talents, preferences, and needs (92%). Face-to face case management review (96%) occurred every ninety days, as required. The individuals had a physical examination (92%) within the past twelve months and all were receiving the medical and mental health supports identified in the individuals' POC recommendations. Overall, the individuals who were living with their families were more engaged with their neighbors and their communities than individuals studied previously who live in congregate residential programs. (The IR was not able to answer most questions related to one individual who was living away at a rehabilitation facility. Many answers pertained to twenty-four individuals.)

The IR identified areas of concern including that several individuals were not receiving services identified in their ISPs/POCs, as follows:

- eight (33.3%) of twenty-four individuals had not been examined by a dentist within the last twelve months;
- five (41.7%) of twelve adults were not receiving recreation or day/employment services;
- five (55.6%) of nine adults were not offered integrated day opportunities;
- sixteen (64%) of twenty-four individuals had Plans of Care that lacked specific outcomes that leads to skill development and increased independence.

b. Families often have great difficulty recruiting and retaining support staff to provide essential in-home support services. Families report that agency-provided support staff lack training in the elements of the individual's service needs, including basic understanding of the unique issues associated with supporting an individual with an Autism Spectrum Disorder or traumatic brain injury. Several families reported deciding to stop trying to recruit needed support staff. The burden of the efforts to find staff and to make sure they were competent was compounded when the staff soon resigned without notice leaving their family member, who has difficulty with change, in emotional turmoil. Many families, again during this review period, reported delays with their support staff being paid in a reasonable time. One family said, "It just wasn't worth it." This problem of maintaining consistent staff was more pronounced in rural areas.

c. Children and adults with DD, other than ID, who also have significant medical needs, were not able to access crisis stabilization (out of home) or in-patient psychiatric services. Children with DD and co-occurring behavioral and/or psychiatric needs lack available and accessible crisis services. Many individuals lacked available and accessible behavioral support services.

d. Families lack accessible guidelines and case management supports to know how to seek and obtain services. Two families reported nearly losing their waiver slots because they did not know how to obtain needed services, thinking that the case manager was responsible. Many families were not aware of REACH crisis services and all reported being unaware of the Individual and Family Support Program. Many families reported difficulty securing the services they need including dental, recreation, day/employment, and behavioral supports. Many families reported learning about the importance of available service options from friends or advocacy organizations.

e. Individuals have been exposed to significant and avoidable risks due to the inadequate oversight and management of adaptive equipment. One individual is unnecessarily bed-ridden because her mechanical lift requires two staff but no more than one is ever on duty. Another individual stays in his apartment and does not engage his community because his motorized wheel chair stalls and he is afraid that it will stall in the community and put him at risk. Following one boy's orthopedic surgery, his wheel chair adaptations were delayed excessively. The delay put him at risk of harm and of required additional, unnecessary surgery to correct a problem that the adaptations were intended to prevent.

By themselves, findings for this subgroup cannot be generalized, with sufficient confidence, to the entire state or to the whole target population. Compliance ratings can be determined with sufficient confidence, however, when findings are consistent with the same positive outcomes and areas of concern found in multiple studies during different review periods for different subgroups and in

different geographic areas. Findings that are unique for one subgroup or one geographic area will be targeted for gathering and verifying facts in future individual review or independent consultant studies.

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

Selected tables with the Individual Review Study's findings are attached (Appendix A). The Independent Reviewer has separated findings from the study into tables focusing on positive outcomes and areas of concern. The findings from the Individual Review Study are also cited in the Independent Reviewer's comments in the Summary of Compliance table. These comments also cite examples of patterns from multiple independent review studies.

5. Case Management and Licensing

The Parties decided that Case Management should be the first specific service listed in their Settlement Agreement. This decision is consistent with the Independent Reviewer's opinion that the case manager is the most important single resource for an individual with ID/DD and his or her family. The case manager is the hub of their services system. It is the case manager who assembles the Individual Support Team and makes sure that the members have the combined expertise to develop the support plan for the individual; assists the individual and family to gain access to needed services; and monitors service delivery and makes service changes as needed. The central importance of the case manager to the individual and family, and to the Commonwealth's ability to achieve the goals of the Settlement Agreement, is the reason the Agreement includes provisions to ensure that:

- case managers do not have a conflict of interest;
- individuals and families have a choice of, and can change, case managers;
- case managers observe and assess whether each individual's support services are properly implemented, address risks, are in the most integrated setting appropriate to the individual's needs, report and document any identified concern, and assemble the ISP team to address it and to document its resolution;
- there is a licensure process that assesses the adequacy of individualized supports;
- the Commonwealth establishes a mechanism to monitor the delivery of case management services to ensure that they comply with performance standards; and
- the Commonwealth maintains sufficient records to document that these requirements of the Agreement are met.

This central importance of case management services is the reason the Independent Reviewer prioritized these provisions for additional independent monitoring during this and the four previous review periods.

The Independent Reviewer again retained the same independent consultant to evaluate the Commonwealth's compliance with the case management provisions and the provisions that govern how the Commonwealth monitors case management to ensure compliance with regulatory and quality standards. The independent consultant's report *Case Management and Licensing Requirements* is attached at Appendix B.

Case Management Availability and Face-to-Face Meetings:
The independent consultant found that the Commonwealth's data dashboard is a viable accountability tool for tracking the delivery of case management services. That is, the data gathered detail the number, type, and frequency of visits, not the quality of the case management services. The data reported indicate that 88% of individuals receive the minimum number of case management visits and that 89% of those eligible are receiving more frequent monthly face-to face visits. The Individual Review Study also found that twenty-three (92%) of twenty-five individuals studied had an ISP that was current, and for 96% there was documentation of face-to-face case management review. The IR has again determined that DBHDS is in compliance with the requirements of III.C.5.a. and V.F.1.

The IR is concerned that DBHDS does not maintain records on the integrity of the Dashboard data. The DBHDS quality managers question the accuracy of data entry at the CSB level. The independent consultant's report includes a suggestion about how to address these concerns and improve CSB data entry performance.

Conflict Free Case management: The consultant reviewed the Commonwealth's policies and forms related to offering individuals and families a choice of service providers. The consultant then surveyed thirty-one randomly selected Authorized Representatives/individuals who had recent annual review ISP meetings. Twenty-five (81%) knew that they had the option to choose, and to change, service providers, including case managers. The IR has determined that DBHDS is in compliance with III.C.5.c. The consultant has included a suggestion in his report that the Commonwealth could increase individual/Authorized Representative awareness of their continuing rights to change providers in user friendly and accessible materials.

Case Management Performance monitoring: Previously, the IR determined that the DBHDS Office of Licensing was the Commonwealth's primary monitor of Case Management performance. The DBHDS Licensing Regulations do not align with the specific requirements of the Agreement (i.e. face-to-face meetings, visit frequency, identifying risks, assembling professionals, etc.). The IR found that the Commonwealth implemented the *360° Reviews*, using its revised *Supports Intensity Checklist* for twenty-two providers (3% of all). The DBHDS monitoring process includes reviews of a sample of case management records and then a document review of providers assigned to deliver services. The independent consultant review determined that it was too early to judge the viability of the *360° Review* process and whether it will fulfill the requirements of the Agreement. The findings from the *360° Reviews* completed, however, were congruent with the findings from the Individual Review Studies. There is a lack of community integration objectives and data to support them. The Commonwealth reports that it plans to address these areas of concern through case manager retraining. DBHDS has Quality Management monitoring activities that indicate progress, however, the IR has determined that the Commonwealth is not in compliance with the requirements of III.C.5.d. The Commonwealth did not provide sufficient records to document that it properly implemented this provision. The IR also determined that the Commonwealth is not in compliance with the requirements of IX.C.

Less Restrictive Options:
This year, the Commonwealth has created and began to use a new ISP form. The form is to be used state wide as annual ISPs become due. The form is designed to confirm that the case manager provides information regarding less restrictive options and a review of most integrated settings. The

Community Resource Consultants have been training case managers and providers on the new ISP format. The consultant surveyed thirty-one randomly selected individuals/families/Authorized Representatives who had recently had annual ISP meetings. Seventy-eight percent of those who answered the phone recalled discussing other and less restrictive options. The IR determined that the Commonwealth is in compliance with III.D.7.

Observation and Assessment:
The consultant found that DBHDS established key indicators to measure the content of face-to face visits, and that the indicators show promise. His review also determined that these measures do not address specific elements of the face-to-face visits, such as, when to assemble the team, how to evaluate significant implementation problems, and how to assess risk when there are status changes. The consultant found that DBHDS had improved parts of its Data Dashboard, which improved its outputs. DBHDS also plans to offer training for case managers related to observations and assessment.

The consultant's evaluation again raised the serious issue of the halo effect of case managers skewing reports toward the positive. DBHDS reports that it has plans to put corrections into place. For example, in October 2014 four CSBs reported that 100% of their 740 individuals had successfully achieved all their Health and Well Being goals. Generally, Health and Well Being goals are less likely to be achieved 100% of the time, since this category is tied to a personal variable like health which is very often out of the control of providers and case managers. Another example that raises concern is that the Individual Review study found that for only five (33%) of fifteen adults reviewed did the case manager develop and discuss employment goals and supports. The IR's Individual Review Studies have found a consistent pattern of individuals not being adequately assisted to gain access to needed services. The IR's Individual Review Studies have found this pattern to exist among different subgroups of the target population, in different geographic regions, and over several review periods. The IR retained an expert consultant to complete a study focused on employment support (attached at Appendix C). The consultant found that with only five (24%) of twenty-one randomly selected individuals did the case manager discuss employment. The case managers reported to DBHDS, however, that they had discussed employment goals with 77% of the 4848 individuals who had ISP annual meetings during the first two quarters of FY 2015.

The IR has determined that DBHDS does not have a mechanism to test the validity of the data reported by case managers and that the reliability of this component of the Data Dashboard raises significant concerns. The IR has determined that the Commonwealth is not in compliance with Section V.F.2.

Case Manager Contacts:
The independent Consultant's evaluation found that the Data Dashboard does not yet reliably reflect CSB performance in regards to the number, type, and frequency of case manager contacts with the individuals. DBHDS Quality Administrators report that poor data entry at the CSB level is the source of the remaining reliability problems in the data included in the Dashboard. Beyond publication of the dashboard and conversations with individual CSBs, DBHDS did not report other strategies to address poor performance outcomes. The IR determined that the Commonwealth continues not to be in compliance with the requirements of V.F.4. DBHDS does not yet have evidence at the policy level that it has reliable mechanism(s) to assess CSB compliance with the DBHDS performance standards relative to case manager contacts.

Office of Licensure Services - Unannounced Visits:
The consultant reviewed all OLS licensing reviews of providers and resulting Corrective Action Plans completed during the second quarter of FY 2015. He also reviewed the OLS tracking sheet for all licensing visits and interviewed DBHDS licensing staff. The consultant found that OLS visits are scheduled and occur in a random fashion that indicates that visits are unannounced and more frequent for those covered by the Agreement. The IR determined that DBHDS remains in compliance with the requirements of V.G.1-2.

Adequacy of Supports:
The consultant's evaluation included extensive document review and interviews with DBHDS Quality And Licensing leaders. His review found that a new OLS Office Protocol, an Internal Auditor's report, and the new *360º Review* process suggest that DBHD is increasingly focusing its Quality Management monitoring process on the adequacy of supports. His evaluation concluded that the outcomes of DBHDS's revised processes would determine their effectiveness. He concluded that although to date there are no data to confirm their overall effectiveness DBHDS's revised processes in its Quality Management Plan may eventually establish that DBHDS is examining the adequacy of supports regularly and consistently. The IR determined that DBHDS is not in compliance with V.G.3.

Case management and Licensing Summary:
DBHDS maintained compliance that it had achieved during prior review periods and strove to accomplish other related provisions. The consultant's review concluded, however, that service providers who repeatedly fail to meet performance expectations, or to fulfill corrective action plans, continue to provided services without further sanctions. The Commonwealth's case management monitoring mechanism was not adequate to achieve a rating of compliance. The Commonwealth plans to implement a revised three-part mechanism to monitor compliance with case management performance standards. To address needed improvements in the Individual Support Planning (ISP) process, DBHDS has recently revised the ISP elements and has implemented training of case managers and private providers. It expects that evidence of improvements will be present after the next (7th) review period.

6. Crisis services
Crisis services are a cornerstone in a community-based services system that prevents the unnecessary institutionalization of individuals with ID/DD. In the Agreement, the Parties agreed that a statewide crisis system would be available for all Virginians with ID and DD as of June 30, 2012. The Commonwealth has complied with crisis services provisions for adults by developing and operating the program elements required by the Agreement. The Commonwealth has begun to implement a statewide crisis system for children and adolescents. It reports having developed new DBHDS internal collaboration with its behavioral health division to improve crisis services. As of April 6, 2015, the end of the sixth review period, a statewide crisis system of services was not yet in place for children and adolescents. As of July 1, 2015, new additional funds have been appropriated to further develop a statewide crisis system for children. The Commonwealth plans to implement elements of the children's crisis system (i.e. single point of entry and crisis call responses) during the next review period and to begin to meet performance standards by December 2016, after the next review period.

The Commonwealth's accomplishments related to a statewide crisis system and areas of concern are highlighted below. In determining compliance ratings, the Independent Reviewer has considered the sixth independent *"Crisis Services Requirements"* study of the Commonwealth's progress. That study focused primarily on quantitative measures of compliance and the findings from the Individual Review Study. The independent consultant's review, *Crisis Services Requirements,* is included at Appendix C.

The Department of Justice also retained independent experts to review crisis and behavioral support services for twelve individuals with ID/DD who had contact with law enforcement, which often resulted in incarceration or admission to a psychiatric hospital. The DOJ reviews of twelve individuals identified inadequacies and, for individual with challenging behaviors, gaps in the crisis system. The number of reviews was not large enough to be able to generalize the findings to the broader population. The findings from these reviews, however, raise serious questions about the performance and effectiveness of the Commonwealth's crisis services for individuals with ID/DD. The identified gaps included:

- a lack of timely response to individuals in crisis;
- a lack of services focused on crisis prevention;
- failure to respond on-site; and
- the frequent involvement of the police and Emergency Services for individuals who threaten aggression or elopement.

The DOJ's consultants' reviews also found that the crisis services programs actively involved the police and Emergency Services to provide needed transportation. Because police and Emergency Services are only able to transport individuals to hospitals or jails, a "direct pipeline to institutionalization" was created. Service providers and CSB staff reported to DOJ that before intervening, REACH crisis services required an assessment of an individual to determine whether the crisis was behavioral or psychiatric. If the crisis was determined to be psychiatric, or if the individual was threatening aggression or elopement, providers were instructed to call 911 or Emergency Services. The DOJ reviews also cited examples of the crisis stabilization programs not being available as a last resort option for short-term out-of-home placement, as an alternative to institutionalization, for individuals:

- with challenging behaviors,
- without a case manager,
- who only used sign language, or
- without stable housing.

The IR's Individual Review Study found a similar example. A crisis stabilization program was not capable of providing a short-term out-of-home alternative to institutionalization for an individual

- with significant medical support needs.

The crisis stabilization programs were not available for these individuals for two reasons. The programs refused to admit individuals with more challenging support needs; or a family chose not to use the program because no staff was competent to meet the essential support needs of their family member. The support needs that the crisis stabilization programs could not meet for these individuals included behavioral, communication, health, safety, or physical care needs.

The Independent Reviewer will prioritize an independent study during the next review period to focus on whether the Commonwealth's REACH crisis services are designed and implemented to provide the required program elements to individuals with significant behavioral, communication, physical care, medical, or housing needs, and who are at risk of institutionalization. The study will

also monitor whether the Commonwealth's crisis system achieves the qualitative measures and expected outcomes of the Crisis Services provisions.

Adult Crisis Services: In 2012, DBHDS initially focused on developing crisis services for adults with ID. After several months of development, DBHDS required the CSB operating the new crisis system to include adults with DD, other than ID. The Commonwealth's crisis services programs for adults, now called REACH, continue to operate at all hours of the day, in all five Regions, and to respond on-site to individuals in crisis. The Commonwealth has not met the requirement for a timely response to each crisis within two hours. Providers and family members reported many examples of the REACH mobile crisis teams not responding on-site to a crisis. Case managers, providers and families continue to refer individuals with ID/DD to REACH. The number of calls to REACH and the number of referrals appears to have increased. Analysis is not possible, however, because the definitions of data have changed between calendar quarters, and some data are missing. DBHDS reported that the number of individuals admitted to psychiatric hospitals increased from forty-seven in the previous two quarters to 119 in the most recent two quarters. This reported increase and high number of psychiatric hospitalizations are significant concern, especially in light of concerns that REACH programs may not be an option for individuals with challenging behaviors, physical care, medical, and communication needs.

The Agreement requires that members of mobile crisis teams be adequately trained. The independent consultant report details the trainings required of mobile crisis team members in each Region. The mobile crisis team training process includes tests to determine whether competencies and skills have been learned. Mobile crisis team supervisors review training outcomes with staff and use team meetings to reinforce the training concepts. Mobile crisis teams provide clinical supervision in a group format. As part of orientation, mobile crisis staff shadow community and Crisis Therapeutic Home staff; prepare and present case reviews; and participate in peer reviews.

The REACH programs reported provided training to 967 stakeholders during the two quarters for this review period. The identified support roles of those trained were: case managers (355), law enforcement (226), Emergency Services (46), and other (331) There is a significant disparity in the amount of training provided by the five REACH teams. Regions II and IV consistently provide fewer trainings to fewer individuals. Neither Region provided any training to law enforcement or emergency services staff during the review period. Training materials are now available on-line. DBHDS requires that new DD case managers complete the training. It plans to require all new ID case managers and CSB Emergency Services staff to complete the training.

During this review period DBHDS developed a work plan for Law Enforcement Outreach. The plan includes:

- communicating with all law enforcement entities about REACH;
- providing information about the new children and adolescent initiative;
- creating and disseminating printed materials;
- conducting regional meetings with law enforcement entities; and
- developing an online training module available to police officers through the Department of Criminal Justice Services website. The training will be implemented starting in July 2015.

The REACH programs trained 226 law enforcement officers during the reporting period. The development and implementation of the *Law Enforcement Outreach* plan are very positive steps.

The IR rated the Commonwealth in compliance with *Section 6.b.ii.C,* because REACH programs trained many officers during this reporting period and the DBHDS plan to insure that all new officers are trained. For the Commonwealth to maintain a rating of compliance, it will require the ongoing and successful implementation of its outreach and training plan and evidence of mobile crisis team members' effective work with law enforcement.

During the second and third quarters of FY 2015, the mobile crisis teams continued to provide crisis service elements: crisis planning, crisis intervention, and crisis response. The consultant's study of crisis services for adults did not evaluate the qualitative aspects or whether these crisis services achieved positive outcomes. Four of the five Regions provided individuals with in-home supports for an average of more than three days.

The Commonwealth is in compliance with *Section III.C.6.b.i.A. and B., with Section 6.b.ii.A. and B.,* and with *Section III.C.6.b.ii.D and E.*

The Agreement requires that mobile crisis teams respond to on-site crises within two hours, and to achieve average response times within one hour in urban areas. DBHDS has defined the urban areas as Region II (Northern Virginia) and Region IV (greater Capitol area). Previously, the mobile crisis response time was measured as the amount of time between when the crisis call was received and when the mobile crisis team arrived at the site of the crisis. The independent consultant learned in the course of the review, however, that the Commonwealth changed how it measures response time. During the review period, the REACH programs determined response time would begin after it completes an internal review and determines that a face-to-face assessment is needed. Furthermore, the Commonwealth cannot report the length of time these assessment decisions require. The purpose of the specific response standards in the Agreement is to offer timely on-site assessment, services, supports, and treatment to de-escalate and help families and providers to assist a person in crisis. DBHDS cannot accurately report the actual length of time for mobile crisis team responses. The IR will continue to determine that the Commonwealth is not in compliance until data regarding response times are complete and are based on the length of time from the call to the time mobile crisis team member(s) arrive at the site of the crisis and when data provided are complete. Although the actual response times are of a longer duration than reported, the shorter than actual times again demonstrated that the mobile crisis teams continue not to respond to all crisis calls within two hours. The Commonwealth has not created second mobile crisis teams, as the Agreement requires, in the Regions that have not met the required response times.

The Commonwealth remains out of compliance with *Section III.C.6.b.ii.G.* and is also not in compliance with *Section III.C.6.b.ii.H.*

Crisis Stabilization:

The Commonwealth is in compliance with four of five provisions related to the development and operations of its crisis stabilization programs. It is in substantial compliance with the fifth provision. Each Region's crisis stabilization program (now called Crisis Therapeutic Homes) is providing short-term alternatives to individuals who need in-patient stabilization services. All Regions Crisis Therapeutic Homes have six or fewer beds. For those admitted to the Crisis Therapeutic Homes (CTH), the programs were used as a last resort to avoid out-of-home placements. Four of the five

Regions have Crisis Therapeutic Homes that are located in community settings. The fifth Region has completed architectural drawings and has recently purchased a community-based site for its program.

The Commonwealth remains in compliance with *Section III.C.6.b.iii.A.,B,D, F and G.* It is in substantial compliance with *Section III.C.6.b.iii.E.*

In this and previous reports, the IR determined the compliance ratings for the crisis stabilization programs were based on whether these programs have been used as a "last resort" for those who were admitted to them. That is, did the REACH crisis stabilization programs admit individuals only after attempts to resolve the crises were not able to maintain the individuals in their current placements? Findings from a small sample in the Individual Review Study and from the Department of Justice reviews of twelve individuals raise significant questions about whether individuals with significant behavioral, physical care, medical, or communication needs are excluded from receiving this crisis stabilization "last resort" program, and whether they experience unnecessary institutionalization as a result. Family members, case managers and CSB staff reported individual examples that painfully illustrated the consequences of not receiving this "last" community-based service option. The individuals with ID and DD and other complex needs who were not offered the "last option" were instead directed to the police and emergency services, which were only able to transport them to hospitals and jails, frequently leading to admissions. During the upcoming review period, the Independent Reviewer will prioritize monitoring the extent to which the REACH services fulfill the Commonwealth's requirements to provide crisis services to all Virginians with ID and DD, and whether these programs effectively maintain individuals' current placements and prevent unnecessary institutionalization.

Children's Crisis Services:

DBHDS completed a detailed plan "*Crisis Response System for Children with ID/DD"* in February of 2014. The plan describes the purpose of the program for children. It outlines key components and a four-phase development process with services launched in July 2014. Initial new funding for crisis support services for children was provided through FY 2015. An additional $4 million has been appropriated for FY 2016. It is commendable that $3.75 of this $4 million FY 2016 will be directed toward this age group and for crisis support. In each Region a gap analysis established that the existing children's crisis services in place vary and that the Regional arrangements, partnerships and service gaps differ. Therefore, DBHDS will allow the available funding to be used differently in each Region. DBHDS reports that it will expect all children's crisis programs, however, to meet statewide standards that align with the requirements of the Agreement. The Commonwealth expects each Region to hire a navigator, to provide the required training, to provide consistent data, and to use the performance measures in the contract with the responsible CSBs to insure the program standards are met.

The statewide children's crisis program standards remain in draft form. It is positive that the standards include most of the service elements and expectations detailed in the Agreement and that the standards will apply to all five regions. The standards do not, however, include expectations that the five regions will provide an alternative residential setting, of no more than six beds, that can provide crisis stabilization for a period not to exceed thirty days. How the Commonwealth meets this standard for the children's crisis system will likely be different from its approach for adults. The approaches may also vary among regions. All Agreement provisions, however, apply equally to the children's portion of the statewide crisis system as they do for adults. The Commonwealth has included basic data collection and training expectations in the standards. Additional data, however, are necessary to determine whether the Commonwealth is properly implementing the requirements of

the Agreement. These include: information about the type of crisis services provided; any use of out-of-home respite or inpatient hospitalization and the length of time a child is admitted; and information about the child's placement after an out-of-home crisis intervention. DBHDS is continuing to finalize the list of trainings. This does not yet include modules on person-centered planning, transition from law enforcement or inpatient settings, cross-system comprehensive planning, or training for CSB Emergency Services or case management staff.

The Commonwealth is not in compliance with *Section III.C.6.a.i, ii, and iii* of the Settlement Agreement because crisis services are not systematically in place and available to children and adolescents. Serious questions have been raised regarding the effectiveness of the timely supports, crisis prevention, and proactive planning, and whether these services are implemented to avoid potential crises and to prevent institutionalization. The IR will prioritize monitoring these quality aspects of crisis services during the next review period.

Outreach to the DD Community:
DBHDS has developed and begun implementation of a plan to reach out to individuals with DD, other than ID, their families and providers. DBHDS has provided trainings, brochures, and reminders to DD case managers to share this information with families. DBHDS has sought the advice of the autism and other advocacy organizations to help distribute information about the REACH programs to connect with more families of individuals with DD and to make them aware of the crisis supports that are available. In January 2015 sixty-five staff attended a training specifically designed for DD case managers.

7. Integrated Day Opportunities
In the Agreement, the Commonwealth committed "to the greatest extent practicable…to provide individuals in the target population…with integrated day opportunities, including supported employment." By September 6, 2012, 180 days after the Agreement was provisionally approved for implementation, the Commonwealth was required to develop and submit a plan to increase integrated day opportunities, as part of a plan to increase supported employment. It produced the plan to increase supported employment but not an implementation of a plan that includes community recreational activities, community volunteer opportunities, and other integrated day activities, as required. The IR directed the Commonwealth to submit the required plan by March 2014. The Commonwealth submitted a preliminary plan in June 2014. It indicated that a comprehensive plan would be submitted in December 2014. The draft plan to increase integrated day opportunities (i.e. the *Community Engagement Plan*) was provided in February 2015.

The Commonwealth's *Community Engagement Plan* includes several commendable features: a specific and outcome oriented definition of integrated day opportunities, the option of consumer directed services, and statewide training. The plan, however, lacks critical elements, such as, the means by which the Commonwealth will:

- assess the need for these services;
- train service planning teams in how to introduce this service concept into a person-centered planning process;
- train CSB staff, and ID and DD Case Managers;
- assess and plan to expand provider capacity; and
- qualify providers.

The independent consultant recommended that these elements be included in her last evaluation of the status of the Commonwealth's planning to develop integrated day activities.

For more than two years, the Commonwealth's redesign of it HCBS waiver has been its strategy to come into compliance with the integrated day provisions of the Agreement. The redesign will include changes to the service definitions and rates, and will align the level of resource allocation with the individual's level of need. The *Community Engagement Plan* lists extensive work between March 2015 and January 2016. None of that work has begun and the Commonwealth has now put implementation largely on-hold. The DBHDS February 23, 2015, quarterly report states that it's implementation activities will not begin until the new restructured waiver is in effect. The earliest that the redesigned waiver can now be in effect is Fiscal Year 2017. Prior to the current implementation delay, the *Community Engagement Plan* would not have establish a baseline for who is now receiving such services until October 2016, four years after its implementation plan was due. The Commonwealth continues not to be in compliance with Sections III.C.7.a and b.i. and it will remain out of compliance until it effectively implements systems reform strategies that facilitate the major changes needed to move from a day system that is characterized by very large congregate facilities to one that provides opportunities in integrated settings with needed supports.

8. Supported Employment

The Commonwealth has provided extensive training related to Employment First, including training and technical assistance to other state agencies. The Commonwealth has developed and, with the input of the SELN AG (Supported Employment Leadership Network – Advisory Group), updated its plan to increase supported employment. During this review period, the SELN AG significantly improved its structure. The SELN AG created subcommittees with targeted responsibilities including a separate group to focus on integrated day opportunities. Completed minutes were written for all meetings; and it is tightening membership to improve consistent attendance. The consultant's study also found, however, that there was no tangible progress on one activity in the employment services plan assigned to the SELN AG – "to develop standards for the delivery of employment".

The SELN AG and the DBHDS Regional Quality Councils (RQC) worked together to review the employment data and quarterly employment targets. Each RQC met twice during this review period with members of the SELN AG, who are also DBHDS employment leaders. The DBHDS Employment Coordinator completed a thorough presentation to each of the RQCs; and the RQCs had in-depth discussions about employment and made recommendations to enhance services. The RQCs and the SELN AG liaison also discussed progress toward implementing the employment services plan.

The IR determined that the DBHDS is in compliance with provision *7.b.i.A*. It continued to provide Regional training on the Employment First policy and strategies. It is also in compliance with III.C.7.c and d. The RQCs reviewed quarterly employment data and made recommendations for improvement. The independent consultant's report, *Integrated Day and Supported Employment Requirements,* attached at Appendix D, includes recommendations for improvements to strengthen the SELN AG – RQC processes so that the RQC's are able to base future recommendations on current and complete information about the status of the employment services plan's implementation. The consultant recommendations also include developing specific outreach strategies for individuals with DD, other than ID, and their support community.

The Commonwealth's state agencies continue to work together to facilitate employment for individuals with disabilities. In northern Virginia, two agencies provided training together that

focused on the employment needs of individuals transitioning from Training Centers to live in the community.

The Commonwealth reported in its biannual report through the second quarter of FY 2015 that 805 individuals were being served in prevocational services. Its report indicated that 785 of these individuals had continued in these services from the previous reporting period.

The Commonwealth recognized previously that the employment data that it compiled in the past did not align with the requirements of the Agreement and were incomplete. After exploring alternatives, the Commonwealth decided to change its source for the data and to collect data about a significantly increased number of individuals. It is the IR's opinion that both decisions were very positive. The new data set includes information about all individuals with ID and DD, including those whose services are temporarily funded by Virginia's Department of Rehabilitative and Aging Services (DARS), rather than about individuals who receive employment supports only through the Commonwealth's HCBS waivers.

DBHDS now has data for 1650 individuals with ID and 254 individuals with DD as a result of its new approach. Wage information was provided for 1332 (80%) of the 1650 individuals with ID and for 148(61%). of the 254 individuals with DD. The data portrays the following about the wages for these individuals:

- 840 individuals with ID (63%) are paid minimum wage or above
- 116 individuals with DD (78%) are paid minimum wage or above
- The average wage for ID individuals is $5.85
- The average wage for individuals with DD is $6.60

Subsequent to the DBHDS Semi-Annual Report on Employment the SELN Data Sub-Committee did further analysis. This analysis indicates that:

- 490 individuals with ID earn less than the minimum wage ($2.48 average)
- 1160 individual with ID earn minimum wage or more ($9.19 average)
- 32 individuals with DD earn less than minimum wage ($3.82 average
- 222 individuals with DD earn minimum wage or more ($8.42 average)

The Commonwealth initially completed a pilot study with four Employment Service Organizations (ESOs). This study confirmed the advantages of collecting data directly from ESOs. DBHDS then completed its first full survey. The data gathered during this review period now aligns with the requirements of the Agreement. The survey response rate, however, was not adequate to determine the number of individuals employed, the hours worked, the length of time, or earnings, all of which the Agreement requires. Only 44% of ESOs provided the requested data. DBHDS estimates that these providers may serve 70% of the individuals. The new data set, therefore, cannot be compared to the old data set that was used in the previous reports. As a result, the Commonwealth is not able to report on progress, which would be determined by comparing two similar sets of data. For example, because the cohorts of individuals are now defined differently, the Commonwealth is not able to report the change in the number of individuals who enrolled or remained in individual or group supported employment. The Commonwealth is not able to determine if progress has been made

toward achieving its employment targets. During the next review period, DBHDS plans to revise its employment targets based on the new definition of the cohort, all individuals with ID and DD, and with more meaningful and comprehensive information.

The IR commends the Commonwealth for the substantial improvement in the accuracy of the data that it gathered, in the alignment of these data sets with the requirements of the Agreement, and because the data can now be provided by type of disability. The IR has determined, however, that the Commonwealth is not yet in full compliance with III.C.7.b.i.B.1.a, b, c, d or e. as it can only report on an estimated 70% of the individuals. It is also not in compliance with III.C.7.b.i.B.2.a and b. The Commonwealth is in compliance with III.C.7.b.i.B.1.d and e. as it provided the data required related to the number of individuals participating in prevocational services.

As reported previously, the Commonwealth has continued to make progress with its HCBS waiver redesign. The Commonwealth designed its strategy, when put into effect, to provide the necessary underpinnings for a more robust set of employment services and supports. The Commonwealth and SELN AG members recognize that to achieve the employment targets will require building provider capacity especially in rural areas. The number of individuals in individual employment is very small in three Regions, and only sixteen in Virginia's most populous Region. The DBHDS Employment Services Plan assigns responsibility to work on this goal to the SELN AG. To date, however, there has been no work or progress reported.

9. Individual and Family Support

The Independent Reviewer's consultant evaluated whether the Commonwealth's design and implementation of its Individual and Family Support Program (IFSP) and other individual and family supports fulfill the qualitative aspects of the definition in Section II.D. and the service requirements of Section III.C.8.b. The Independent Reviewer also convened two focus groups with individuals and families to obtain their input about the design and implementation of the Individual and Family Support Program. These focus group meetings included individuals and families who live in two different geographic areas, one rural and one urban. In prior Reports to the Court the IR determined that during FY 2013 and FY 2014 the Commonwealth had complied with the quantitative requirements of Section III.C.8.b. i.e. to support at least 700 individuals and families in FY 2013 and 1000 in FY 2014. The Agreement definition limited eligibility to those who were not already receiving services under Virginia's HCBS waivers.

The consultant confirmed that the Commonwealth designed and implemented Individual and Family Support Program to provide a one-time financial amount of up to $3,000 to eligible individuals and families on a first come-first serve basis. The Commonwealth determined that a single criterion would be utilized to determine those "most at risk of institutionalization." That criterion is defined as being on the Commonwealth's waitlists for services under the HCBS waivers. The consultant confirmed that the Commonwealth utilized $1.5 million, half of the $3 million available, to provide a one-time financial award to 600 individuals during the first half of FY 2015. The Commonwealth has $1.5 million remaining. When it completes the second set of awards, the Commonwealth will again exceed the minimum number of 1000 beneficiaries during FY 2015. When it does so, the Commonwealth will again have complied with the quantitative requirements of III.C.2.

The consultant found that the Commonwealth's Individual and Family Support Program was not designed or implemented to meet the qualitative aspects of the definition (Section II.D) of an

individual and family support program. The IFSP did not include a comprehensive and coordinated set of strategies to ensure access to person and family-centered resources and supports. To solicit input in the design of the program, the Commonwealth documented that it met once with a stakeholder group in April 2012. DBHDS reports that it met more frequently and that it considered information gathered from other states. It did not provide documentation of these meetings, the options considered, or the rationales for decisions. Stakeholder participants reported to the IR that DBHDS established tight parameters for the IFSP: the timeline in the Agreement for the first awards, the number of individuals to be served and the amount of money available. To establish a maximum annual award to a single individual of $3,000, the Commonwealth divided the available $3 million by the minimum number of 1000 individuals it is required to support annually. It decided to award up to this one-time amount on a first come-first serve basis. The Commonwealth recognized that an average award of less than the maximum would result in more than the minimum required number of individuals who would receive an award annually. The Commonwealth determined that "most at risk of institutionalization" is defined as everyone who is on its waitlists for services under the HCBS waivers.

In designing and implementing the IFSP, the Commonwealth did not analyze the existing individual and family supports available or determine the gaps. When the stakeholder met with DBHDS for its documented annual meeting in 2012, 2013, and 2104, there was no discussion as to how to achieve a comprehensive and coordinated set of strategies to ensure that individuals and families have access to needed resources and supports. Since DBHDS implemented the IFSP, there has been no other ongoing formalized mechanism for stakeholder input. Such a mechanism would help identify gaps in the comprehensiveness or coordination of current strategies and help to guide the evolution of the IFSP to meet the definition of an individual and family support program in the Agreement.

The Commonwealth has made changes each year to the IFSP application and its internal administrative processes. DBHDS completed an internal audit of the IFSP program in July 2014. The audit recommended that timeline goals be set for the review of applications and appropriate notifications. DBHDS again modified its internal processes hoping to streamline the program and to reduce response time. DBHDS did not consistently vet these modifications with stakeholders to ensure that the changes adequately address the issues and concerns.

Overall, the independent consultant found that overall the IFSP does not include adequate design or program evaluation strategies to make progress toward achieving the goal of a comprehensive and coordinated set of strategies for individual and family support. There has been no assessment of individual and family supports available statewide or any goals, objectives and timelines for developing a comprehensive and coordinated set of strategies. There has not been an evaluation of whether the IFSP has made progress toward achieving a comprehensive and coordinated set of strategies. Furthermore, the benefits of the IFSP are not coordinated with other support resources.

The DBHDS case management operational guidelines define the functions of case management for individuals on HCBS waiver waitlists who have more intensive medical or behavioral needs or those with multiple encounters with the crisis system. The IFSP guidelines indicate that one IFSP objective is to support the continued residence of an individual with ID/DD in his/her own home or family home. To accomplish this objective, coordination of various services and supports beyond a one-time monetary award is essential. Yet the Commonwealth reports that case managers do not

have any role in facilitating access to or in coordinating the use of any IFSP funds awarded with other individual and family supports.

The number of applications for the IFSP has grown substantially between FY 2013 and FY 2015, from 1,744 to 5,500, a 315% increase. The amount requested also increased during that period from $2,303 to $2,500, an increase from 77% to 83% of the maximum allowed. Current IFSP staffing resources were not sufficient to meet the turnaround goals for handling and responding to applications even before the most recent increase in the number of applications. These limited staff resources are not adequate to identify other available resources or to coordinate with other agencies for each of the 5,300 applications received in FY 2015. Families and advocates interviewed by the independent consultant consistently indicated frustration over the lack of DBHDS transparency about the IFSP processes and the perceived lack of responsiveness from IFSP staff at DBHDS.

Individuals Most at Risk of Institutionalization:

The Commonwealth has determined those "most at risk for institutionalization", as required by the Agreement, with a very broad definition. It determined that presence on either the ID or DD waiver waitlists is the sole criterion for who is most at-risk for institutionalization and therefore eligible to receive a monetary award under the IFSP. This broad definition is in keeping with the primary tenets of traditional individual and family support programs: that all individuals with intellectual and developmental disabilities and their families need and deserve supports and should not have to prove that they are more deserving than others. At the same time, stakeholders interviewed shared an almost universal uneasiness that the design of the IFSP may be inherently unfair to those who need it the most. A common theme expressed was that the needs of individuals and families on the waitlists varied dramatically. There was no prioritization based on individual situations that are more important or urgent than others. For example, stakeholders expressed uneasiness as to whether the IFSP should fund summer camp or violin lessons over health and safety-related needs. The ID waitlist is further stratified into "urgent" and "non-urgent," but this differentiation is not factored into the determination of most at-risk or any prioritization. On its face, this lack of "most at risk" prioritization between "urgent" and "non-urgent" appears contradictory.

Most stakeholders shared concerns that higher-income and better-educated families are more likely to be able to get the application completed and submitted within the very small window that makes funding even possible. The current guidelines require that an individual or family submit an application on one given day during the funding period to have any real chance of being approved. This is a significant hardship for many. Individuals and families cannot predict if a personal crisis, such as a family member illness, support staff not being available, or a car breakdown may occur on the first day of the funding period. If this occurs, and they cannot make it to the post office, they have virtually no opportunity to receive funding. Such crises have the potential to occur more frequently for those with fewer social and financial resources, which reinforces the concern that these individuals and family members are at a disadvantage in terms of successfully receiving an award under the IFSP.

First Come-First Serve:
Overall, the first come-first served structure has been unwieldy and impractical. The volume of applications postmarked on the first day of the application period exceeds the number that can be funded. For example, of the 3,300 applications received in the first funding period for FY 2015, 2,278 were postmarked on the first day. Only 600 (26.3%) of those post marked on the first day were approved for funding based on the available dollars. DBHDS acknowledges that it was impossible to determine which of the 600 among those 2,278 were actually "first-come." The resulting first-day volume also creates a sizeable backlog of applications and notifications that takes months to work through.

Maintaining sufficient records to demonstrate proper implementation:

The Commonwealth has not defined outcome or satisfaction indicators for the IFSP, other than the number of individuals/families who receive a one-time fund award. Data are not collected that relate to performance, impact, or satisfaction. DBHDS acknowledges the importance of this and the lack of feedback from individuals and families. DBHDS reported that it is drafting a survey, which it expects to distribute in the near future. The consultant concluded that DBHDS also does not yet have a comprehensive picture of systemic individual and family supports on the broader scale. Neither has it determined the indicators or data needed to demonstrate that the individual and family supports offered are comprehensive and coordinated.

The IR determined that the Commonwealth is not in compliance with Section III.C.2. The individual and family support program does not include the qualitative aspects included in the definition of an individual and family support program. The program does not include a comprehensive and coordinated set of strategies that ensure access for individuals and families to a range of needed resources and support.

The IR determined that the Commonwealth is not in compliance with Section IX.C. DBHDS has not determined the indicators or data needed and does not maintain sufficient records to demonstrate a comprehensive and coordinated set of strategies that ensure individuals and families have access to a range of person-centered and family centered supports.

10. Guidelines For Families Seeking Services
The Independent Reviewer's consultant reviewed the Commonwealth's published guidelines for families seeking services, and whether it had provided the guidelines to appropriate agencies for use in directing individuals with ID and DD and their families to the correct point of entry to access services.

The consultant found that during this review period, the Commonwealth had updated guidelines ("Just the Facts") for individuals and families seeking services funded by Virginia's HCBS waivers. These guidelines did not include information regarding how and where to apply or how to obtain services for either the nearly ten thousand individuals who are already on the waitlists, or for the others seeking services who do not yet know how to apply to get onto the waitlists.

The IFSP is available to individuals/families on the waitlists. DBHDS published IFSP guidelines in February 2014, however, these guidelines had not been updated during the past year and are now outdated and incorrect.

Publishing and Providing Updated Guidelines Annually to Appropriate Agencies:
DBHDS has posted updated "Just the Facts" guidelines on-line during this review period. Finding the guidelines is difficult, and likely not possible without detailed instructions. For example, locating guidelines for families seeking services requires the family to understand what services his or her family member might be eligible for, to know to search for the DBHDS website, and to navigate a series of multiple choices through four separate links to arrive at, and recognize that the *ID waiver fact sheet* may help. Once the family opens the fact sheet, someone must read a nine-page document without a table of contents to find the final section *Accessing ID Waiver Services*. This process must be repeated for the Day Support and IFDDS fact sheets. These fact sheets explain how to access services funded under the Commonwealth's HCBS waivers, but do not mention that submitting an application typically results in being placed on a waitlist for many years. These fact sheets do not include guidelines to access other resources and supports while waiting to be awarded a waiver slot, or to gain access to services funded through the HCBS waivers.

The Commonwealth published and distributed IFSP guidelines to some appropriate agencies, such as Community Service Boards, agencies providing private case management, and some ID and DD advocacy organizations. The Commonwealth did not provide either set of guidelines to agencies that are frequently the first point of contact for a child with a significant developmental disability and his or her family, such as hospital neonatal intensive care units, pediatrician organizations, and special education offices of public schools.

The Independent Reviewer determined that the Commonwealth is not in compliance with Section III.C.8.b. The IFSP Guidelines, as updated February, 2014, are not sufficient in terms of detail, accuracy and accessibility to individuals and families, to be effectively used to direct individuals in the target population to the correct point of entry to access services. The "Just the Facts" guidelines are not designed for individuals/families who are not yet aware of how to apply for waiver services or for those who have applied and have been placed on the waitlists. These guidelines are not truly accessible and have not been provided to agencies which are the likely first point of contact for families seeking services.

IV. CONCLUSION

The IR reported in the last Report to the Court that the Commonwealth had achieved compliance with certain requirements of the Agreement. During this, the sixth review period, the Commonwealth through its lead agency, DBHDS, and its sister agencies has maintained compliance with these same provisions and has come into compliance with additional requirements. The Commonwealths leaders have continued to meet regularly and to collaborate to develop and implement plans to address the Agreement's requirements and to improve people's lives. The IR also reported in the last Report to the Court that the Commonwealth lagged significantly behind schedule. It continues to do so. There have been significant delays in the it's compliance with requirements that are critical to an effective community-based services system for individuals with ID/DD. For two years, the Commonwealth's primary strategy to come into compliance has been the redesign of it HCBS waiver program. The Commonwealth's primary strategy to increase independent living options has been to ensure that the rental assistance it offers is ongoing for a substantial number of individuals.

Although the Commonwealth has made continued efforts and progress on its planning the implementation of these strategies, it did not put the redesign of its HCBS waiver into effect. The IR determined that the Commonwealth continues to be in non-compliance with many provisions of the Agreement. Furthermore, the Commonwealth will remain in non-compliance until it successfully implements needed system reforms.

The IR previously reported that the Commonwealth had implemented and refined a discharge planning and post-move monitoring process, and that it had achieved and maintained compliance over multiple review periods with most of the Discharge Planning and Transition provisions. The IR did not monitor or provide updated compliance ratings for these provisions during this review period. The IR confirmed during this review period that the Commonwealth maintained compliance with provisions that require increased frequency of visits and oversight by case management and licensing. It has also developed the required program elements of crisis services for adults. The Commonwealth provided increased community supports for individuals with complex needs by creating Bridge Funding and exceptional rates. It has begun new initiatives to increase behavioral support resources. The Commonwealth has newly come into compliance with provisions related to its plan to increase independent living options, with case managers offering choice of service providers, and with requirements that the Regional Quality Councils review of employment targets.

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

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

V. RECOMMENDATIONS

The Independent Reviewer recommendations to the Commonwealth are listed below. The Independent Reviewer requests a report regarding the Commonwealth's actions to address these recommendations and the results by September 30, 2015.

Children's Crisis Services

1. The Commonwealth's statewide program standards for children's crisis services should include the requirements for crisis stabilization settings, follow-up and monitoring, staff development, and evaluation of service quality including user feedback.

2. The Commonwealth training requirements should parallel those for adult crisis services, with modifications needed for children's services. These trainings should include modules on person-centered planning, transition from law enforcement and in-patient facilities, cross-system comprehensive planning, and training for CSB Emergency Services or case management staff.

3. The Commonwealth should collect data and information about the types of crisis services provided. This includes any use of out-of-home respite or inpatient hospitalization, the length of time a child is admitted; and information about the child's placement after an out-of-home crisis intervention.

Adult Crisis Services

4. DBHDS should gather, analyze, and provide consistent information about the services provided through REACH. This information should include the number of individuals with DD, other than ID, who call or are referred to REACH and the number REACH served. This should also include information about all individuals who experience psychiatric hospitalizations or incarceration. The information gathered should include the individual's name, whether REACH staff was involved, the duration of hospitalization or incarceration, and whether the individual experienced repeated hospitalizations or incarcerations.

5. The Commonwealth should provide support, including training and technical assistance, to community providers about how to identify individuals who are behaviorally or psychiatrically at-risk, how to proactively plan to avoid future crises, and how to de-escalate crises that do occur without removing them from their current placements to a hospital, psychiatric facility, or jail.

6. DBHDS should establish training expectations for the REACH programs to train CSB Emergency Services staff. It should also determine how to ensure that existing ID and DD Case Managers are trained. Additionally, it should establish expectations for ongoing outreach to law enforcement personnel in each REACH area to expand upon the training module and to develop effective working relationships.

Integrated Day Activities

7. The DBHDS should develop an implementation plan to provide integrated day activities that includes the timelines and measurable milestones for each set of planned actions. The Commonwealth should include details of how it will prepare the current provider network for very substantial needed changes.

Supported Employment

8. The Commonwealth should create targets for subgroups of the population. These subgroups should include individuals who are currently in group supported employment and pre-vocational services, individuals transitioning to the community from Training Centers, individuals transitioning from school to adult services, and individuals who receive new waiver slots under the Agreement.

Licensing

9. The DBHDS Office of Licensure Services should compile an annual trend report on the results of Licensing reviews, Internal Auditor reviews, and 360° Reviews. The trend report should include results of reviews across CSBs. This will help the Commonwealth to discover needed system improvements and to plan and implement corrective actions.

Case Management

10. DBHDS should develop training, monitoring tools, and clinical support for case managers. Doing so will ensure that they have the skills, tools, and clinical supports to assess identified and unidentified risks and to determine whether supports are being implemented consistent with each individual's safety protocols and needs.

11. DBHDS should ensure that case managers receive training in the specific elements of their face-to-face visits. These elements include when to convene the team, how to evaluate significant implementation problems, and how to assess risk when there are status changes.

Individual and Family Support

12. The Commonwealth should develop and implement a formalized and ongoing mechanism for stakeholder input to help guide the evolution of the Commonwealth's individual and family support program as person-and family-centered, and to incorporate a comprehensive and coordinated set of strategies.

Guidelines for Families Seeking Services

13. The Commonwealth should publish easily accessible and user friendly guidelines for families seeking services designed to assist individuals/families who:
    - are not yet aware how to apply and obtain HCBS waiver service
    - are on waitlists for services through HCBS waivers, or
    - have been awarded a HCBS waiver slot.

14. The Commonwealth should provide its published guidelines to the agencies that an individual/family is likely to contact first when a child is diagnosed with a significant disability or when an individual is new to the Commonwealth. These agencies include hospital neonatal intensive care units, pediatric organizations, and public school special education programs.

VI. APPENDICES

A. INDIVIDUAL REVIEWS

B. CASE MANAGEMENT AND LICENSING REQUIREMENTS

C. CRISIS SERVICES REQUIREMENTS

D. INTEGRATED DAY ACTIVITIES AND SUPPORTED EMPLOYMENT

E. INDIVIDUAL AND FAMILY SUPPORT and GUIDELINES FOR FAMILIES SEEKING SERVICES

F. LIST OF ACRONYMS

APPENDIX A

INDIVIDUAL REVIEWS
October 7, 2014 – April 6, 2015

Completed by:
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Demographic Information

Sex	N	%
Male	16	64.0%
Female	9	36.0%

Age ranges	N	%
Under 21	12	48.0%
21 to 30	8	32.0%
31 to 40	2	8.0%
41 to 50	1	4.0%
51 to 60	2	8.0%

Levels of Mobility	N	%
Ambulatory without support	19	76.0%
Ambulatory with support	1	4.0%
Uses wheelchair	4	16.0%
Confined to bed	1	4.0%

Authorized Representative	N	%
Guardian	12	48.0%
Authorized Representative	8	29.2%

Type of Residence	N	%
Individual/family home	23	92.0%
Supported apartment	1	4.0%
Rehabilitation facility	1	4.0%

Highest Level of Communication	N	%
Spoken language, fully articulates without assistance	20	80.0%
Communication device	2	8.0%
Gestures	1	4.0%
Vocalizations	2	8.0%

NOTE: The Reviewers were not able to visit one of the twenty-five individuals and Could Not Determine (CND) the answers to most questions for that individual. Two families were not able to accommodate a home visit. One was interviewed over the phone. A mother and her son were interviewed in a hospital lobby. In the following tables "n" is the number of individuals for whom the question was applicable. Some questions are only applicable if the individual is an adult, or does not live with his or her family, or does has the condition. Consider the % of CND answers for each question when reviewing the % of Yes and No answers in the tables below.

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

Healthcare Items - positive outcomes				
Item	**n**	**Y**	**N**	**CND**
Did the individual have a physical examination within the last 12 months or is there a variance approved by the physician?	25	92.0%	4.0%	4.0%
Were the Primary Care Physician's (PCP's) recommendations addressed/implemented within the time frame recommended by the PCP?	25	92.0%	4.0%	4.0%
Were the medical specialist's recommendations addressed/implemented within the time frame recommended by the medical specialist?	23	87.0%	8.7%	4.3%
Is lab work completed as ordered by the physician?	25	88.0%	8.0%	4.0%
Are physician ordered diagnostic consults completed as ordered within the time frame recommended by the physician?	18	94.4%	0.0%	5.6%
If ordered by a physician, was there a current physical therapy assessment?	4	100.0%	0.0%	0.0%
If ordered by a physician, was there a current occupational therapy assessment?	6	100.0%	0.0%	0.0%
If ordered by a physician, was there a current speech and language assessment?	7	100.0%	0.0%	0.0%
If applicable per the physician's orders,				
Is there monitoring of seizures, if applicable per the physician's orders?	6	83.3%	0.0%	16.7%
Is there monitoring of seizures, if applicable per the physician's orders?	6	83.3%	0.0%	16.7%
Is there any evidence of administering excessive or unnecessary medication(s) (including psychotropic medication?	25	0.0%	96.0%	4.0%

Healthcare Items – areas of concern				
Item	**n**	**Y**	**N**	**CND**
Did the individual have a dental examination within the last 12 months or is there a variance approved by the dentist?	25	56.0%	36.0%	8.0%
Were the dentist's recommendations implemented within the time frame recommended by the dentist?	25	56.0%	32.0%	12.0%
If ordered by a physician, was there a current psychological assessment?	11	81.8%	18.2%	0.0%
If ordered by a physician, was there a current nutritional assessment?	5	60.0%	20.0%	20.0%
Are there needed assessments that were not recommended?	25	24.0%	72.0%	4.0%
Is there monitoring of fluid intake, if applicable per the physician's orders?	10	80.0%	10.0%	10.0%
Is there monitoring of bowel movements, if applicable per the physician's orders?	14	78.6%	14.3%	7.1%

Healthcare Items –Psychotropic Medications - areas of concern				
Item	**n**	**Y**	**N**	**CND**
If yes, is there documentation that the individual and/or a legal guardian have given informed consent for the use of psychotropic medication(s)?	18	61.1%	33.3%	5.6%
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?	14	42.9%	28.6%	28.6%

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

Individual Support Plan Items – positive outcomes				
Item	**n**	**Y**	**N**	**CND**
Is the Individual's Support Plan/Plan of Care current?	25	92.0%	8.0%	0.0%
Is there evidence of person-centered (i.e. individualized) planning in the development of the Individual's Support Plan/Plan of Care?	25	96.0%	4.0%	0.0%
Is the individual receiving supports identified in his/her individual support plan?				
Residential	25	96.0%	4.0%	0.0%
Medical	25	100.0%	0.0%	0.0%
Health	18	88.9%	11.1%	0.0%
Mental Health	15	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's Support Plan/Plan of Care?	25	92.0%	4.0%	4.0%

Individual Support Plan Items – areas of concern				
Item	**n**	**Y**	**N**	**CND**
Are all essential supports listed?	25	80.0%	16.0%	4.0%
Does the Individual's Support Plan/Plan of Care have specific outcomes and support activities that lead to skill development or other meaningful outcomes?	25	32.0%	64.0%	4.0%
If the individual requires an adaptive environment, have all the adaptations been provided?	7	71.4%	28.6%	0.0%
If the individual requires adaptive equipment, is the equipment available?	15	60.0%	33.3%	6.7%
If applicable, were employment goals and supports developed and discussed?	15	33.3%	60.0%	6.7%
Is the individual receiving supports identified in his/her individual support plan?				
Dental	24	62.5%	33.3%	4.2%
Day/Employment	12	58.3%	41.7%	0.0%
Recreation	12	58.3%	41.7%	0.0%
Communication/Assistive Technology	10	60.0%	40.0%	0.0%

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

Integration items – areas of concern				
Item	n	Y	N	CND
If applicable, were employment goals and supports developed and discussed?	15	5	9	1
If no, were integrated day opportunities offered	9	44.4%	55.6%	0.0%
Does typical day include regular integrated activities?	15	41.7%	58.3%	6.7%
Do you participate in integrated community volunteer activities?	25	16.0%	84.0%	0.0%
Do you participate in integrated community recreational activities?	25	56.0%	40.0%	4.0%

APPENDIX B

CASE MANAGEMENT AND LICENSING

By: Ric Zaharia Ph.D.

of

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

Case Management and Licensing Requirements

By

Ric Zaharia, Ph.D., FAAIDD
Consortium on Innovative Practices

April 24, 2015

Executive Summary

The Independent Reviewer for the *US v. Commonwealth of Virginia* Settlement Agreement requested a follow-up review of the Licensing and Case Management requirements of the Agreement. This review updates the findings from previous reports on these areas.

DBHDS (Department of Behavioral Health and Developmental Services) licensing rules (12VAC 35-105-1240) regard the Office of Licensing Services (OLS) as the compliance mechanism for Community Service Board (CSB) case management performance under their contracts with the Commonwealth. Monitoring case management performance, however, has been expanded to include case management expectations that have been added to the DBHDS Internal Auditor's periodic Operational Review of CSBs. In addition, DBHDS is widening the scope of OLS case management reviews through a process called *360^{o} Review*. While the Internal Auditor's Operational Review of CSBs clearly measures case management performance of the CSBs, it does so infrequently. The *360^{o} Review* process was initiated in the fall of 2014 is, as yet, not established as an effective performance monitoring strategy.

DBHDS efforts to achieve compliance in the monitoring area continue. The exposure of individuals and the system to the negative impacts of providers who repeatedly fail to meet performance expectations or correction plans continue. One residential provider during the fall of 2014 had repeat citations with no additional consequence besides another CAP.

The Agreement contains an overarching requirement that data collected by DBHDS for the purposes of continuous improvement be "reliable". DBHDS has not tested for the reliability of case manager data referenced in the Agreement, whether for case manager visits or their assessment of the individual's accomplishment of goals. This could be simply addressed in the same manner as HCBS audits – requiring supervisors to conduct samplings of records and report the performance they discover.

The Compliance Table on the next page summarizes the assessment of compliance described in the narrative report below. This review assessed ten requirements in the Agreement. Five of the ten are in compliance. For five of the ten requirements the progress made by the Commonwealth toward compliance has not been sufficient to achieve compliance. Recommendations are made on approaches to achieve compliance. Suggestions for improvement are offered for consideration.

Compliance Table

Settlement Agreement Section	Settlement Agreement Language	Compliance as of 4/15/15 (10/24/15)	Page
III.C.5.a Case Management	*The Commonwealth shall ensure that individuals receiving HCBS waiver services under this Agreement receive case management.*	**Compliance** (same)	4
III.C.5.c Case Management	Case management shall be provided to all individuals receiving HCBS waiver services under this Agreement by case managers who are not directly providing such services to the individual or supervising the provision of such services. The Commonwealth shall include a provision in the Community Services Board ("CSB") Performance Contract that requires CSB case managers to give individuals a choice service providers from which the individual may receive approved waiver services and to present practicable options of service providers based on the preferences of the individual, including both CSB and non-CSB providers	**Compliance** (Non-Compliance)	5
III.C.5.d Case Management	*The Commonwealth shall establish a mechanism to monitor compliance with performance standards.*	**Non- Compliance** (same)	6
III.D.7	*The Commonwealth shall include a term in the annual performance contract with the CSBs to require case managers to continue to offer education about less restrictive community options on at least an annual basis to any individuals living outside their own home or family's home (and, if relevant, to their Authorized Representative or guardian).*	**Compliance** (none)	8
V.F.1 Case Management	*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** (Same)	9
V.F.2 Case Management	*At these face-to-face meetings, the case manager shall: observe the individual and the individual's environment to assess for previously unidentified risks, injuries needs, or other changes in status; assess the status of previously identified risks, injuries, needs, or other change in status; assess whether the individual's support plan is being implemented appropriately and remains appropriate for the individual; and ascertain whether supports and services are being implemented consistent with the individual's strengths and preferences and in the most integrated setting appropriate to the individual's needs. If any of these observations or assessments identifies an unidentified or inadequately addressed risk, injury, need, or change in status; a deficiency in the individual's support plan or its implementation; or a discrepancy between the implementation of supports and services and the individual's strengths and preferences, then the case manager shall report and document the issue, convene the individual's service planning team to address it, and document its resolution.*	**Non-Compliance** (same) [also Assessed through Individual Service Reviews]	10
V.F.4 Case Management	*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** (same)	11
V.G.1-2 Licensing	*The Commonwealth shall conduct regular, unannounced licensing inspections of community providers serving individuals receiving services under this Agreement. 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.*	**Compliance** (same)	12
V.G.3 Licensing	*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** (same)	13
Section IX.C	Requires that there be *"…sufficient records to document that the requirements of the Agreement are being properly implemented…"*	**Non-Compliance** (same)	7

Case Management

Case Management Availability

III.C.5.a

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

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Methodology

- Reviewed October 2014 Data Dashboard.
- Interviewed Dee Keenan.

Findings

The Data Dashboard continues to have viability as an accountability tool for the tracking of the delivery, but not quality, of case management services. The Dashboard's effectiveness is now centered on the accuracy of data entry at the local CSB level.

The October 2014 Data Dashboard shows that system-wide 88% of the individuals eligible for in-home case management are receiving the required visit minimums. Of the individuals eligible for monthly face-to-face visits, 89% are receiving those minimums. No records were provided to support or show the integrity of the data in the Dashboard.

Conclusion

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

DBHDS is not in compliance with IX.C.

Recommendations toward Achieving Full Compliance

None

Suggestions for Departmental Consideration

DBHDS might request Data Entry Improvement Plans from the CSBs below 90% might begin to challenge CSBs between 90-95% to achieve the 100% reached by four CSBs in October and clearly establish a minimum expectation that all CBSs will achieve 95%.

Choice-based, Conflict-free Case Management

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.

Methodology

- Reviewed *Individual Choice Form* (10.1.10) and *Virginia Informed Choice and Notification Form* (1.21.15).
- Telephone interviewed ARs/individuals who are in out-of-home placements from a list of 4,176 individuals who had an ISP during Oct.-Nov.-Dec. 2014. The reviewer selected 63 names randomly drawn (every fifth name alphabetically) with at least one drawn from each CSB, 2 from CSBs with over 100 names, 3 from CSBs with over 200 names, and so on. The final 31 individuals who responded represented 25 CSBs and all the Health Planning Regions.
- Interviewed Dee Keenan.

Findings

The reviewer telephone surveyed 31 authorized representatives/individuals who had recent annual ISP meetings, who were randomly selected and who answered phone calls. Eighty-one percent (81%) knew that they had the choice of choosing/changing service providers, including the case manager.

Case managers present individuals or their authorized representative with a formal Choice Form "when there is a request for a change in provider/s, when additional services are initiated, or when the individual is dissatisfied with the current provider."

Conclusion

DBHDS is in compliance with III.C.5.c. and has ensured that case managers are giving individuals a choice of service providers.

Recommendations towards Achieving Full Compliance

None

Suggestions for Departmental Consideration

DBHDS might consider educating individuals or their authorized representative of their continuing rights to change providers in user friendly and accessible materials, such as in the annual guidelines it publishes per Section III.C.8.b.

Case Management Performance Monitoring

III.C.5.d

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

Methodology

- Reviewed all data available on Supports Efficacy Checklist as applied during Oct.-Nov.-Dec. 2014.
- Reviewed one Internal Auditor's report on a CSB completed during Oct.-Nov.-Dec. 2014.
- Interviewed Dee Keenan, Keven Schock, Chanda Braggs.

Findings

Based on information provided to this reviewer, no CSBs were required to generate a CAP by Licensing during Oct-Nov-Dec 2014.

DBHDS reports that six (6) Operational Reviews were completed through March of 2015. Only one was provided to this reviewer for the last quarter of 2014, but it is an excellent example of the kind of case management performance review that the system requires.

Twenty-two (22) provider programs (3% of all providers) were reviewed using the Supports Efficacy Checklist (formerly Supports Efficiency Checklist) from Oct 2014 through January 2015; these Checklist reviews, which covered 56 individuals in total, are a major component of the *360° Review*, in which OLS staff look at a sample of case management records and then conduct a document review of providers assigned to deliver services to the individual. It is too early to judge the value of these *360° Reviews,* but it is disappointing to learn that in this initial group four (4) providers had no data to support the objectives/services they were assigned and almost a third were missing community integration goals/objectives, which is congruent with findings from our Individual Service Reviews. DBHDS reports that it is will be revisiting this issue with CSB case managers through re-training.

Licensing regulations (12VAC35-105-10 to 105 1410) do not align specifically as to the case management expectations detailed in the Agreement (i.e. regularized face to face meetings with the individual being served, enhanced visit frequency, identifying risks to the individual, offering choice among providers, assembling professionals and non-professionals who provide supports, identifying risks). As structured, the current process for the licensing reviews cannot determine if the provisions of the Settlement Agreement are being properly implemented. However, a set of regulatory changes is being developed which may impact this area.

The latest OLS Office Protocol has been revised to include the eight (8) areas identified in the Agreement (V.D.3.) for monitoring. This is a positive modification towards CSB performance monitoring.

OLS does not regularly compile the results of licensing reviews into a report on trends related to compliance patterns across CSBs.

Conclusion

Although the Department's quality management activities indicate progress, DBHDS is not currently in compliance with the requirements of III.C.5.d, a mechanism to monitor CSB compliance with performance standards. Section IX.C also requires that there be "…sufficient records to document that the requirements of the Agreement are being properly implemented…" and those were not provided to the reviewer.

Recommendations toward Achieving Full Compliance

At least annually OLS should compile a trend report on Licensing/Internal Auditor/*360° Reviews* results for case management. Detecting and reporting patterns and frequencies in the results of reviews across CSBs ensure that needed system improvements are discovered and that corrective action can be planned and implemented. Data warehousing software should enable OLS to inform these reports as the use of this software is implemented on monitoring data.

Continue to evaluate and revise the Supports Efficacy Checklist process for effectiveness.

DBHDS should identify the statistically minimum sample size OLS needs to validate the findings of any CSB case management review. The current "minimum sample of 10 cases" does not ensure that CSBs with caseloads over 200 are receiving a valid sampling. A 10% sample size, such as now required at provider agencies, would provide more confidence in the findings, their generalizability, and their representativeness of agency performance.

Suggestions for Departmental Consideration

None

Less Restrictive Options

III.D.7

The Commonwealth shall include a term in the annual performance contract with the CSBs to require case managers to continue to offer education about less restrictive community options on at least an annual basis to any individuals living outside their own home or family's home (and, if relevant, to their Authorized Representative or guardian).

Methodology

- Reviewed new ISP form (12.16.14).
- Telephone interviewed ARs/individuals who are in out-of-home placements (see above for more information).
- Interviewed Dee Keenan.

Findings

This reviewer telephone surveyed 31 families/authorized representatives/individuals who had recent annual ISP meetings, who were randomly selected and who answered phone calls. Seventy-eight percent (78%) recalled other, less restrictive service options being discussed at the annual meeting.

The revised ISP form (dated 12.16.14), which was rolled out to the system earlier this year and is to be used system-wide as annual ISPs come due, includes a section that is designed to confirm that education is offered and a review of most integrated settings is conducted. Community Resource Consultants have been training CSB staff and providers on the new format.

Conclusion
DBHDS is in compliance with III.D.7, the annual revisit of most integrated options per the recently revised ISP. The telephone interviews confirm that families/authorized representatives/individuals are discussing alternative options at the annual meeting.

Recommendations toward Achieving Full Compliance
None

Suggestions for Departmental Consideration
None

Face-to-face Case Management

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.

Methodology
- Reviewed October 2014 Data Dashboard.
- Reviewed records maintained to demonstrate that visits occur regularly as dictated by individual needs.
- Telephone interviewed ARs/individuals who are in out-of-home placements (see above for more information).
- Interviewed Dee Keenan.

Findings
As reported above, the October 2014 Data Dashboard shows that system-wide 88% of the individuals eligible for in-home case management are receiving the required visit minimums. Of the individuals eligible for monthly face-to-face visits, 89% are receiving those minimums. No records were provided to support or show the integrity of the data in the Dashboard

The reviewer telephone surveyed 31 families/authorized representatives/individuals who had recent annual ISP meetings, who were randomly selected and who answered phone calls. Two thirds of this group knew the case manager made regular face-to-face visits; some knew the frequency. A third of the group did not know the case manager's visit schedule. Sixty-one percent (61%) believed that their assigned support coordinator "kept a good eye on things on their behalf."

Conclusion
DBHDS is in compliance with V.F.1.

Recommendations to Achieve Full Compliance
None

Suggestions for Departmental Consideration
DBHDS might request Data Entry Improvement Plans from the CSBs below 90% and might begin to challenge CSBs between 90-95% to seek to achieve the 100% reached by four CSBs in October.

Observation and Assessment

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. If any of these observations or assessments identifies an unidentified or inadequately addressed risk, injury, need, or change in status; a deficiency in the individual's support plan or its implementation; or a discrepancy between the implementation of supports and services and the individual's strengths and preferences, then the case manager shall report and document the issue, convene the individual's service planning team to address it, and document its resolution.

Methodology
- Reviewed the planned changes to the ISP and the ISP process.
- Evaluated data collection tool.
- Reviewed October 2014 Data Dashboard.
- Interviewed Dee Keenan.

Findings
For this Agreement objective (to measure the content of the face-to-face visits) the key indicators settled on by DBHDS (Health & Well Being, Community Inclusion, Choice and Self-Determination, Living Arrangement Stability, and Day Activity Stability) showed promise. However, these measures do not address specific elements of the face-to-face visits, such as when to convene the team, how to evaluate significant implementation problems, assessing risk when there are status changes, etc.

As with the larger parts of the Data Dashboard, these latter five measures, which DBHDS developed, are collected centrally from the CSBs through the CCS3 (Community Consumer Submission 3). Edits were made to the CCS3 extract in 2014 which improved its outputs and additional training is planned for case managers regarding reports on the five measures.

These latter data pieces may be captured through other processes being tested by DBHDS, but the halo effect of case managers skewing reports for the Data Dashboard toward the positive is a serious issue. There are plans to put corrections in place to correct for this via the ISP, but the reliability of this component of the Data Dashboard remains a large question. For example, in October 2014 four CSBs (Dickenson, Henrico, Northwestern, Rockbridge) reported that 100% of their Health and Well Being goals were being successfully achieved for 740 individuals; while this is certainly plausible, there is no mechanism to test the validity of this data given that Health and Well Being goals are the least likely to be achieved 100% of the time, since it is the one category that is tied to a personal variable like health which is very often out of the control of providers and case managers.

Conclusion

Based on this review DBHDS is not in compliance with Section V.F.2. This section is also assessed in the Individual Service Review study, which has found in each previous reporting period that most ISPs do not include baseline or measurable outcomes. The oversight for this issue is clearly vested in OLS, which does not routinely examine case manager notes relevant to an incident in its SIR and death investigations.

Recommendations towards Achieving Full Compliance

DBHDS should develop methods to show validity in the reported data from case managers. This will involve sampling individual records to verify agreement between what is documented and what is reported. This could be delegated to case management supervisors.

OLS should establish a minimum investigation protocol that always includes review of case manager notes in the period preceding an incident or a death.

DBHDS should develop training, clinical support, and monitoring tools for CMs to ensure that they have the skills and clinical supports to assess for identified and unidentified risks and to determine if supports are being implemented consistent with safety protocols and the individual's needs.

Specific elements of the face-to-face visits, such as when to convene the team, how to evaluate significant implementation problems, assessing risk when there are status changes, etc. will need to be assessed or measured. The *Support Coordination ECM Onsite Report* appears to have potential for addressing this, but it is optional and not required of the field.

Suggestions for Departmental consideration:

DBHDS should consider dialogues with CSB managers about the integrity of the five indicators now reported in the Data Dashboard.

Case Manager Visits

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

Methodology

- Reviewed any data gathered that demonstrates that the data provided by CSBs is complete and reliable.
- Reviewed October 2014 Data Dashboard.
- Interviewed Dee Keenan.

Findings

The Data Dashboard does not yet reliably reflect CSB performance for the Settlement Agreement requirement of "*a mechanism to collect reliable data from the case managers on the number, type, and frequency of case manager contacts with the individual*". DBHDS quality administrators have identified poor data entry at the CSB level as the source of the remaining reliability problems in the Dashboard. However, beyond publication of the dashboard and conversations with individual CSBs, there do not appear to be strategies that would ensure CSBs improve their data entry processes or address poor performance outcomes.

Conclusion

DBHDS is not currently in compliance with the requirements of V.F.4. DBHDS does not yet have evidence at the policy level that it has reliable mechanism/s to assess CSB compliance with their performance standards relative to case manager contacts.

Recommendations towards achieving Full Compliance:

DBHDS should implement strategies that direct CSBs improve their data entry.

Suggestions for Departmental consideration:

The Drumwright/Keenan CSB input matrix review creates a rich information pool for DBHDS and should be an annual event.

DBHDS should require that CSBs achieving less than 50% on all Data Dashboard measures provide a 'data entry improvement plan'; CSBs achieving less than 90% should provide a 'case management performance improvement plan.'

Licensing

Unannounced OLS Visits

V.G.1-2

The Commonwealth shall conduct regular, unannounced licensing inspections of community providers serving individuals receiving services under this Agreement. 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.

Methodology:

- Reviewed all provider licensing reviews/CAPs during Oct.-Nov.-Dec. 2014.
- Reviewed OLS tracking sheet for all Licensing visits Oct-Nov-Dec 2014.
- Interviewed Keven Schock, Chanda Braggs.

Findings

Visits are scheduled and occur in a random fashion that indicates they are unannounced and more frequent for those covered by the Agreement.

Conclusion

DBHDS is in compliance with the requirements of V.G.1-2.

Recommendations to Achieve Full Compliance

None

Suggestions for Departmental Consideration

None

Adequacy of Supports

V.G.3

Within 12 months of the effective date of this Agreement, the Commonwealth shall ensure that the licensure process assesses the adequacy of the individualized supports and services provided to persons receiving services under this Agreement in each of the domains listed in Section V.D.3 above and that these data and assessments are reported to DBHDS

Methodology

- Evaluated the revised OLS Office Protocol.
- Reviewed all CSB and provider licensing reviews/CAPs during Oct.-Nov.-Dec. 2014.
- Reviewed all data available on use of the Supports Efficacy Checklist during Oct.-Nov.-Dec. 2014.
- Reviewed one Internal Auditor's report on a CSB completed during October-November-December 2014.

- Interviewed Dee Keenan, Keven Schock, Chanda Braggs.

Findings
A new OLS Office Protocol, an Internal Auditor's report, and the new *360° Review* suggest the quality management monitoring process is being increasingly focused on the adequacy of supports. The outcomes of these revised processes will determine their effectiveness.

The revised processes in the Quality Management Plan may eventually establish that DBHDS is examining the adequacy of supports regularly and consistently. To date there is no data to confirm that this is the case.

There is a theme at OLS that educational approaches to providers are preferred to applying more serious consequences.

Conclusion
DBHDS is not in compliance with V.G.3.

Recommendations towards Achieving Full Compliance
DBHDS should continue to test-evaluate-revise its quality management processes.

Quality Management planning should consider using a similar methodology to the HCBS audits: request that case management supervisors review samples of case management records and report their reliability and internal consistency.

While providers should be given every opportunity to respond to training and corrective action plan approaches, the OLS licensing mechanisms should ultimately be in use to weed out providers who repeatedly fail to meet performance expectations or correction plans, sooner rather than later.

Suggestions for Departmental Consideration
None

Summary

DBHDS continues to accomplish requirements in the Agreement and to strive to accomplish those not yet achieved. Upcoming submission of emergency rule revisions for OLS, full roll-out and evaluation of the *360° Review* process, and implementation of the proposed Waiver Re-Design which will be submitted to the General Assembly for approval in November of 2015, should position DBHDS to accomplish many more of the Agreement requirements.

APPENDIX C

CRISIS SERVICES REQUIREMENTS

By: Kathryn du Pree MPS

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

PREPARED BY KATHRYN DU PREE, MPS
EXPERT REVIEWER

May 7, 2015

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SECTION 1: OVERVIEW OF REQUIREMENTS

Donald Fletcher, the Independent Reviewer has contracted with Kathryn du Pree as the Expert Reviewer to perform the review of the crisis services requirements of the Settlement Agreement for the time period 10/7/14- 4/6/15. The review will determine the Commonwealth of Virginia's compliance with the following requirements:
The Commonwealth shall develop a statewide crisis system for individuals with ID and DD; provide timely and accessible supports to individuals who are experiencing a crisis; provide services focused on crisis prevention and proactive planning to avoid potential crises; and provide in-home and community-based crisis services that are directed at resolving crises and preventing the removal of the individual from his or her current setting whenever practicable. This will be the fifth review of crisis services and prevention and will focus on the recommendations made by the Independent Reviewer in his report of December 2014.

SECTION 2: PURPOSE OF THE REVIEW

This review will build off the review completed last fall for the review period through 10/6/14 and the recommendations the Independent Reviewer made in his last Report as a result of the conclusions and findings of that review.

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

- The Commonwealth's ability to serve adults with developmental disabilities in terms of crisis prevention and intervention services ensuring this target population, including those on the waiting list, has case management services to facilitate full access to crisis services and stabilization programs, and access to community supports to prevent future crises
- The Commonwealth's ability to provide crisis prevention and intervention services to children with either intellectual or developmental disabilities. The DBHDS was still in the planning stages last during the Fall 2014 review and had not implemented crisis services for children with the exception of Region II and III.
- The DBHDS' actions to reach out to individuals with DD and their families and train all DD Case Managers to ensure families of individuals with DD are aware of and can access crisis services
- The status of training of CSB Emergency Services workers to be completed by 6/14
- The Commonwealth's plan to reach out to law enforcement and criminal justice personnel to link individuals with intellectual and developmental disabilities with crisis intervention services to prevent unnecessary arrests or incarceration
- The number of individuals who were removed from their homes to an out-of-home placement during a crisis, the duration of the placement and the number of individuals who were not able to return to their original home or residence
- The status of locating a permanent crisis therapeutic home in Region IV
- The quality of crisis services that individuals are receiving from the five regional REACH programs
- The satisfaction of the families who have utilized REACH services for a family member

SECTION 3: REVIEW PROCESS

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

Document Review: Documents reviewed included:

1. The Children's Crisis Standards: draft 12-1-14
2. The Region IV Gap Analysis and Program Development Updates for children and adolescent crisis services
3. HPR II Children Crises Services October 2014 Report and ID/D Needs Assessment Report
4. State Quarterly REACH reports for 10/1/14-12/31/14 and 1/1/15-3/31/15
5. REACH Flyer 2014
6. DD Outreach Plan Update 2-11-15
7. Work Plan for Law Enforcement Outreach
8. Original and Update Timeline for House Search Region IV
9. REACH Coordinators Meeting Minutes-10-14 and 11-14

Interviews: I interviewed Connie Cochran the Assistant Commissioner for Developmental Services, Heather Norton the Director of Community Services, Michele Ebright the Crisis Services State Coordinator, the Region IV ID/D Director, REACH CTH Coordinator and Medical Director; members of the Region I REACH Advisory Council (RAC) and a Case Manager in Region I. I visited the CTH in Region IV. I was able to interview one of the families that received REACH services for their child living at home and a member of the Region I RAC that had used REACH services to determine their level of satisfaction and elicit any recommendations they have for improvement. I appreciate the time that everyone gave to contributing important information for this review.

Individual Reviews: I selected ten individuals randomly who use REACH services to determine the quality of the services provided. The focus of this review was to determine the quality of in-home supports for individuals experiencing crises and the training and assistance provided to their families. I reviewed their REACH service records.

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

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

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

i. Provide timely and accessible support to individuals who are experiencing crises, including crises due to behavioral or psychiatric issues, and to their amilies;

ii. Provide services ocused on crisis prevention and proactive planning to avoid potential crises; and

iii. Provide in-home and community –based crisis services that are directed at resolving crises and preventing the removal of the individual rom his or her current placement whenever practicable.

A. REVIEW OF THE CRISIS SERVICES PLAN TO SERVE CHILDREN AND ADOLECENTS

The Commonwealth focused on developing crisis services for adults to date. Crisis services for children and adolescents are not yet available across the state although there is various supports available in different parts of Virginia to respond to children and adolescents in crisis that may include young people with ID/D. Regions II and III have initiated their crisis service response for this age group.

The Independent Reviewer directed DBHDS to develop a plan for crisis services for children and adolescents with ID/D by March 31, 2014. I reviewed this plan during the last review cycle and the regions' gap analyses and plans. The DBHDS plans include: "*My Life, My Community: A Road Map to Creating a Community Infrastructure "*on January 6, 2014. This document included a section about Children's Crisis Supports. This plan outlined key components of a crisis response system for children based on the review of children's crisis programs across the country. It provided a foundation for development of these services and set various expectations for availability, a service continuum and systemic values. A more detailed planning document, "*Crisis Response System or Children with ID/D"* was issued by Connie Cochran, Assistant Commissioner, Division of Developmental Services, DBHDS, on February 4, 2014. It describes the purpose of a crisis response system for children, how DBHDS will establish children's crisis operations, and the expectations and timeline for regions submitting proposals to secure funding and departmental approval of individual regional initiatives.

DBHDS anticipated the children's crisis response system being developed in four phases beginning with the department's notification of funding (3/14); with Regional Program Developers/Navigators hired by 6/14; and services launched in July 2014. The DBHDS projected each region would expand services for children and adolescents over two to three years.

Funding was provided to each region through FY15 with a base allocation of $225,000. DBHDS has requested $4 million in additional funding for crisis services for FY16 that has been approved. The department will allocate $3.75 million of this amount for children and adolescent crises services. The remaining $250,000 will be used for training and data needs related to children and adolescent services. This will give each region a base of almost $1 million. This is compared to $2 million that each region receives to fund its REACH program for adults. The DBHDS was considering if the full amount of $4 million would be allocated for children and adolescents last fall. It is commendable that the full amount will be allocated to assist this age group and specifically for crisis support.

Regions I, III and V completed the gap analysis during the previous review period. Regions II and IV completed their analyses during this review period. Region II was providing coordinated crisis services for children and adolescents starting in June 2014.

Region II submitted its analysis on 10/27/14. It has an existing Crisis Response System for children that focuses on prevention and intervention. Each CSB has a 24/7 crisis screening and intervention for children that need emergency hospitalization; it has partnerships with private hospitals to fund children that do not have health insurance and need inpatient care or a partial hospitalization program; limited crisis stabilization beds; a state funded Mobile Crisis Stabilization Program through Arlington CSB; and a network of providers that support children with intensive in-home support, day treatment and mental health supports. The region has gaps in short-term crisis stabilization and funding, and individuals experience service delivery fragmentation. Case management and other services are more limited for children with DD, other than ID. Residential treatment is not funded under the HCBS DD Waiver. Region II planned to focus on hiring staff and developing training at the time the gap analysis was written. The Region II report did not include any projection of need for crisis services.

Region IV submitted its needs assessment on November 2014. It provided a full report that included a literature review and examples of national best practices and exemplary programs operated in other parts of the country. Region IV used national, state and local school data to try to project the level of need for children and adolescent crisis services. The most recent school data included 2,382 students with autism, 1,425 other students with DD and 1,780 students with ID. There was no information about how many of these students may have co-occurring conditions. The region does not have any tracking system or data source of children and adolescents who experience crises in the region or in Virginia. The region conducted focus groups with family members and CSB staff. They did a survey with families, providers and CSB staff as well. These sources identified the primary gaps and needs for crisis services: support to caregivers; professional training; mobile crisis services; prevention; respite; too few waivers; insufficient inpatient treatment; funding and system linkages. The region plans to focus on outreach, cross training of professionals, and adopt successful program models. These include the REACH model and the Children Services Trauma Response Program. Region II will also establish a Children's Crisis Services Regional Advisory Council.

Heather Norton provided an update of each region's development status. Regions II and III have operating programs to coordinate crisis services for children and adolescents. Region III is using its existing REACH program and it has certified some of its Qualified Mental Health Professionals (QMHP) to serve both adults and children. Region II is sub-contracting with the CRII mobile crisis program that will interface with the REACH program. REACH will address prevention needs and the CRII program will provide mobile crisis support. Region II has served eight children and Region III has served twelve children and adolescents during this reporting period. Region I is planning to use the existing four CSB mobile crisis teams to provide crisis support but still needs to hire its Navigator/Regional Program Developer. Region IV plans to connect through its existing programs. However Region IV does not have the Navigator or any contracts in place. Region V plans to use the Region III model but the contract will be held by a different CSB than the CSB that operates the REACH program for adults.

DBHDS plans for the need for out of home respite to be provided by using existing crisis beds. The department will analyze whether there is sufficient capacity as the children and adolescent services are implemented. DBHDS allows each region to determine its own administrative model to coordinate crisis services for children and adolescents. However, each region is to hire a navigator, provide the required training, provide consistent data and use the performance measures in the contract with the responsible CSBs to insure the program standards are met.

Children's Crisis Services Program Standards: I have reviewed the Program Standards that are in draft form. It is always important to have program standards so that services are delivered to individuals consistently and the same range of supports are provided regardless of where an individual child resides. It is particularly important that these standards are comprehensive and clearly defined for Virginia's Children's Crisis Service System that will rely on a vast network of community and inpatient providers and will operate under different administrative structures. The standards include the expectations for the crisis service system: trained providers, crisis assessment and intervention services; a focus on maintaining children in their homes and providing their families with needed support and education; linkages with appropriate inpatient care; collaboration with the child's treatment team; and the development of measurable outcomes for the service system goals. Service elements will include 24 hour crisis response 365 days a year; crisis response within two hours in rural areas and one hour in urban areas; trained clinical staff; a Child Navigator; training for families and staff; crisis intervention and prevention plans; and in-home support services. The standards do not include a requirement for crisis stabilization when a child needs to be removed from his or her home for a period of time. The Settlement Agreement requires that the Commonwealth provide a residential setting of no more than six beds that can provide crisis stabilization not to exceed thirty days. The department's goal to support children in their homes is laudable. However the Commonwealth must be able to respond timely and appropriately when a child needs a short term out of home setting for crisis stabilization.

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

There is a description of the basic training topics and expectations for outreach to providers, schools, law enforcement, and other community partners. The training topics include important areas. It does not include-modules on person-centered thinking and behavioral support planning; transition from inpatient settings; or cross-system comprehensive planning. The DBHDS is continuing to finalize the training requirements.

The topics list also does not include training for CSB ES or case management staff. DD Case Managers will also need to be trained to understand how to access these services for the children they support. The Child Navigator is responsible to develop training materials and conducting workshops. The Navigator is also responsible for outreach and to follow up on a

monthly basis for the first six months after initial contact. I question whether the Navigator will have sufficient time to fulfill all of the responsibilities assigned to this position.

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

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

Individual Reviews of Children – DBHDS provided the records of six children that are receiving crisis prevention and intervention services through the Region III REACH program. Region III has started its crisis support for children and adolescents using its existing REACH program with licensed staff to provide crisis response. At the time of this review the program had served twelve children and shared the records for six of these individuals. The purpose of this review was to have an initial understanding of the effectiveness of the approach one region was implementing to coordinate crisis services for children and adolescents.

Individual 1 is eighteen and has a history of psychiatric admission. The family contacted REACH three times between 12/14 and 1/15. REACH provided de-escalation support and provided out of home stabilization through the CTH since he is eighteen. REACH partnered with New River Valley Community Services (NRVCS) for clinical and psychiatric services. REACH provided parent education and responded to family requests for assistance. NRVCS developed an effective service plan to include a fifteen day stabilization plan to prevent readmission; arranged for psychiatry services; coordinated with the treatment team; provided family education; taught coping skills and supported the individual's transition to adult services.

Individual 2 is ten years old. Her behaviors were becoming more challenging for her family and in-home support staffs were resigning. REACH started immediately to assist the family and had daily contact for eighteen days after the referral. In-home supports and training were provided; linkages were made with the school and community clinicians; triggers were identified and a positive behavioral support plan was implemented.

Individual 3 is fifteen years old. He is in and out of residential treatment and lives with his family when he is stable. He threatens to harm himself and has homicidal ideations. REACH was initially contacted by the hospital. REACH responded immediately and met the family at the hospital. He was admitted but REACH stayed involved. They responded immediately after he returned home but ran away. They continue to support the family and coordinate with the Case Manager. They have developed objectives and interventions to be used when he returns home.

Individual 4 is thirteen years old. REACH has offered supports to his family caregiver who will not accept any assistance. REACH has been involved with his school program. This assistance has allowed the school to continue to educate this adolescent. His behaviors were threatening his continued enrollment before REACH was involved.

Individual 5 is fourteen years old. REACH became involved after the police made a CPS referral. The father had rejected support prior to this referral. REACH responded quickly, developed a crisis prevention plan and contacted the school. He was placed in a short- term residential program as a result of the CPS complaint. REACH will be involved in his discharge planning and return to the community.

Individual 6 is a fifteen year old. He was referred because of his threatening and defiant behavior toward his mother and concerns for her safety. He had intensive care coordination, therapeutic day treatment, psychiatry, and outpatient counseling. REACH responded immediately to the referral meeting him that evening to develop a crisis stabilization plan that was implemented for fifteen days. REACH trained and supported his mother, insured his psychiatric care was increased and included a medication review. Subsequent to implementing the stabilization plan REACH continued to collaborate with the mental health providers, and trained the family and providers in crisis prevention techniques.

These are all excellent examples of an effective crisis prevention and intervention program for children and adolescents that uses and coordinates existing community resources to more effectively support these children to remain safely at home. Region III has decided to expand its REACH team to serve children using the REACH model. This seems entirely appropriate. This is the only region that plans this approach although Region V plans to replicate the REACH model administered by a different CSB. DBHDS will need to determine if the other models are effective once they are implemented.

The Commonwealth is not in compliance with *Section III.C.6.a.i, ii, and iii* of the Settlement Agreement because crisis services are not systematically in place and available to children and adolescents.

Recommendations: The DBHDS has developed a road map to initiate the planning process for serving children and adolescents with I/DD who are in crisis. The elements it proposes are necessary for effective services to be developed. It has begun the process of developing program standards. These standards need to include, requirements for crisis stabilization settings, follow-up and monitoring, staff development, and monitoring and evaluation of service quality to be complete. It is positive that DBHDS has drafted program standards and will have the same expectations of all five regional children's crisis service systems. While regional differences exist in terms of the existing capacity and expertise to serve children and adolescents, it is important that the same expectations are set by DBHDS for each regional program and that the regions are monitored to insure consistent implementation. I suggest it expand the list of data requirements to parallel the information provided for the REACH programs with the necessary modifications. DBHDS also needs to confirm in its program standards that Children's Crisis Services is available to all children and adolescents ages 3-17. Region II's reports still reference children solely. It should be made clear that the intention of the program is to serve everyone though age seventeen.

The DBHDS has set timelines for two major outcomes of crisis services: response time and the availability of mobile crisis services. Each region should develop a work plan that details each area of its responsibility for implementation with timelines and responsible staff or organizations. They should report progress on a semi-annual basis. The full training curriculum should be shared with the Independent Reviewer when it is completed.

B. REACH SERVICES FOR ADULTS

Regions received referrals for 132 individuals in Quarter II and 140 individuals in Quarter III. The total of 272 individuals who were referred in this review period compares with a total of 232 in the previous review period. The data no longer includes information about the total number of individuals REACH serves. There were a total of 520 calls in Quarter II of which 153 required a face-to-face response. There were a total of 1,058 calls during Quarter III of which 246 were of a crisis nature. The data is defined differently in each quarter.

In this reporting period, Case Managers made 75% of the referrals in Quarter II and 64% in Quarter III. During Quarter II only Regions I an V report that DD Case Managers made referrals and in Quarter III DD Case Managers made referrals in Regions I, IV and V. DBHDS reports that nineteen individuals with DD were referred in Quarter II and thirty-four individuals with DD were referred in Quarter III. This is a significant increase over other reporting periods but it now includes individuals who have both ID and DD. Previous reports only included individuals whose primary diagnosis is DD. The reports need to specify the referrals for individuals whose primary diagnosis is DD so the Parties are able to determine if this service is effectively serving individuals on the DD waiver or those who are on the waiting list for the DD waiver.

Services were provided as follows during the reporting period:

- ✓ 154 adults received CTH services and 91 adults received Mobile Crisis Support during QII
- ✓ 134 individuals of the individuals served in QII required crisis stabilization in the CTH program and 69 received crisis stabilization from Mobile Crisis Support. Region II did not provide any crisis stabilization from its Mobile Crisis Support and Region V provided it for only two of the individuals served
- ✓ Ninety-four adults received CTH services and 134 adults received Mobile Crisis Support during QIII. All of these individuals received crisis stabilization

DBHDS reports on the outcomes for individuals who are hospitalized as a result of the crisis and what involvements REACH has with them prior to and post hospitalization. DBHDS is to report if these individuals eventually return home or if an alternative placement needs to be located for them. Thirty-one individuals in FY15 QII and eighty-eight individuals in FY15 QIII required some type of psychiatric hospitalization. This is an increase of seventy-two individuals compared to the previous reporting period. Of the thirty-one reported in QII nineteen retained their original placement and six transitioned to a new community placement post discharge. Two utilized the CTH program. Others may have remained hospitalized at the time of the report.

During QIII 53% of the individuals retained their placement with the majority (fifteen) in Region IV. A total of thirty-six retained their original placement. Other individuals returned to

family homes, transitioned to a community residence or used the CTH as a step down. At the time of the report 15% remained hospitalized but DBHDS was only able to report on sixty-two of the eight-eight individuals that were hospitalized. DBHDS did not report on the final disposition for the 13% that used the CTH. The high number of psychiatric hospitalizations and the significant increase in hospitalizations is troubling.

DBHDS reports that the REACH program remains actively involved with all individuals that are hospitalized when they are aware of the hospitalization. They participate in the admission, attend commitment hearings, attend treatment team meetings, visit and consult with the treatment team. REACH is working with the CSB ES personnel to increase their awareness of these hospitalizations. The Commonwealth is exploring ways to acquire data on admissions to private hospitals.

Training- The REACH programs provide training to stakeholders every quarter. The audiences include law enforcement personnel, CSB Case Managers, ES workers, and other community partners. During the reporting period a total of 967 individuals were trained across the five regions. This included 226 law enforcement officers, 355 CSB Case Managers, 46 ES staff, 9 hospital staff, and 331 noted as other. The regions are inconsistent in the amount of training they provide. Regions II and IV are consistently lower than the other three regions providing training to the various community partners and neither region trained any police officers or ES staff during the review period. DBHDS should place training requirements on the REACH programs. There is no specific information to determine if any DD Case Managers have been trained although training materials are now available on the website and required for new DD Case Managers. DBHDS should report on training for this staff category.

DBHDS does recognize the regional differences in training. It has developed a training presentation for case management staff and ES personnel. This presentation was first offered in January and attended by sixty-five professionals. DBHDS plans to require this training of all new emergency workers and case managers. It will be offered online as part of employee orientation. It is part of the online training available to both ID and DD Case Managers. I spoke with one DD Case Manager who has accessed the online training, was invited to the January training session and has received numerous email notifications and updates about the REACH program.

Outreach to the DD Community- DBHDS has developed and begun implementing a plan to reach out to individuals with DD, their families and providers, and the broader community serving individuals with DD, other than ID. DD Case Managers are now receiving training and information regarding REACH services. Each region shares its brochure with all case managers. The DBHDS will issue a reminder asking the case managers to share this information with families. ES staff are trained to understand that REACH services are also a resource for individuals with DD. DBHDS is enhancing its communication with state and private mental health hospitals. REACH staff present to statewide and local conferences to educate families and providers. Public Guardian Supervisors were trained in July 2014. DBHDS has sought the advice and recommendations of the Autism Society of Central Virginia to reach more families of individuals with DD to make them aware of the crisis supports that are available. DBHDS continues to work with other partners including Commonwealth

Autism Service, Virginia Autism Center for Excellence and the Arc of Virginia to help distribute information about the REACH Program. The Virginia 211 site was updated in December 2014 to include current information about the REACH crisis services and its availability to both individuals with ID or DD. The training session in January was specifically for DD Case Managers and was attended by sixty-five staff.

Recommendations:

DBHDS should gather, analyze and provide consistent information about the services provided through REACH, the number of individuals with DD referred and served and more specific information about individuals who experience psychiatric hospitalizations. It is useful to know if these are appropriate hospitalizations or necessitated by the lack of community crisis and behavioral support; the involvement of REACH staff; the duration of hospitalization; and the number of individuals who experience repeated hospitalizations. DBHDS should establish training expectations for the REACH programs to train ES staff and determine how to insure existing ID and DD Case Managers are trained. It should also establish expectations for the ongoing outreach to law enforcement personnel in each REACH area to expand upon the training module and develop cooperative relationships. DBHDS should monitor compliance with its standards and expectations and take corrective action when indicated.

C. REVIEWS OF INDIVIDUALS USING REACH

This review included reviewing the services ten randomly selected individuals received. The focus of this review was to determine the adequacy of mobile crisis supports for individuals who are supported to remain in their homes. Two individuals were randomly selected from each region. Six of the individuals lived in group homes, two individuals lived at home with their families, one person was referred upon discharge from jail, and one was referred upon discharge from a residential facility. In the latter two situations REACH was very involved in assisting the individual to transition back to the community. The initial response to the referral was face-to-face for six of the individuals and through a phone consultation for the remaining four individuals. These all appear to be appropriate responses. Response time for face-to-face responses is determined using the criteria of either one or two hours. Response time is considered met for phone responses if the initial call was responded to immediately. Regions I, II and III responded in a timely fashion consistently. These three regions also all had interim crisis plans. Regions I and II had assessments for both individuals reviewed. Region I and Region IV established community linkages or connected with existing community supports for both of the individuals it serves. Region V showed evidence of the involvement of the Case Manager for both of the individuals it serves.

Only one of the randomly selected individuals to review experienced a psychiatric hospitalization during their involvement with REACH Region IV. REACH maintained its involvement with this individual. REACH provided training for staff, mobile crisis services, a crisis stabilization plan and use of the CTH program. The individual could benefit from a thorough medication review and clinical support from professionals with experience supporting an individual with a co-occurring condition.

REACH was contacted for one individual when he was being released from jail and provided support and coordination for his transition to a new community residential provider.

I spoke with one mother whose daughter was served by REACH. She was very satisfied with the services and response of the REACH team. She was particularly pleased with the access her daughter has to the CTH program that she has used on both an emergency and planned basis. She received some training but does not remember receiving a crisis support plan.

Table 1 below summarizes the findings of the ten individual reviews. The ratings of Not Met for In-home supports (IHS) do not necessarily note that it was needed, but that it was not part of the interim plan. All of the individuals reviewed have stayed in their homes or residential placements.

TABLE 1 REVIEWS OF INDIVIDUAL USING REACH SERVICES

	RESPONSE TIME	ASSESS MENT	INTERIM PLAN	CSCP	IHS	TRNG	CASE MNGR	COMM LINKS
1	MET	MET	MET	NOT MET	NOT MET	MET	NOT MET	MET
2	MET	MET	MET	MET	MET	MET	NOT MET	MET
3	MET	MET	MET	NOT MET	MET	MET	MET	NOT MET
4	MET	MET	MET	MET	MET	MET	NOT MET	MET
5	MET	NOT MET	MET	NOT MET	NOT MET	NOT MET	NOT MET	NOT MET
6	MET	MET	MET	MET	NOT MET	MET	MET	NOT MET
7	NOT MET	NOT MET	NOT MET	NOT MET	NOT MET	NOT MET	NOT MET	MET
8	MET	MET	MET	NOT MET	MET	MET	MET	MET
9	NOT MET	MET	MET	NOT MET	NOT MET	NOT MET	MET	NOT MET
10	NOT MET	NOT MET	NOT MET	MET*	MET	MET	MET	MET
% MET	**70%**	**70%**	**80%**	**40%**	**50%**	**70%**	**50%**	**60%**

- Individual #10 was not initially supported well by the REACH program at the time of the most recent referral (8/22/14). The CM re-wrote the interim crisis plan because of its weaknesses. The CSCP is noted as available because the REACH staff found a previously developed CSCP and used it that proved to be reasonably successful.

As a result of these reviews I have concerns about the development of Cross Systems Crisis Plans; the involvement of the Case Manager with REACH; and the need to more formally link to community resources to support the individual in a consistent fashion to prevent future crises. It will be important to interview Case Managers, providers and REACH Coordinators in future reviews. This will provide a more comprehensive understanding of the extent to which the REACH programs fulfill the Commonwealth's crisis services responsibilities. Often data were missing so there was not written evidence that a component of REACH was in place.

Conclusions: The DBHDS is not in compliance with *Section III.C.6.a.i, 6.a.ii, and 6.a.iii.* The program elements are in place for adults with ID and the REACH teams are generally meeting the expectations for serving this specific population although there are areas for program improvement and documentation. However, DBHDS does not have a statewide crisis system in place for children and adolescents who experience a crisis; nor can DBHDS assure that it is reaching all of the individuals with DD who need and may benefit from the crisis system.

SECTION 5: ELEMENTS OF THE CRISIS RESPONSE SYSTEM

6.b. The Crisis system shall include the ollowing components:
i. A. Crisis Point of Entry
The Commonwealth shall utilize existing CSB Emergency Services, including existing CSB hotlines, or individuals to access information about and referrals to local resources. Such hotlines shall be operated 24 hours per day, 7 days per week and staf ed with clinical professionals who are able to assess crises by phone and assist the caller in identifying and connecting with local services. Where necessary, the crisis hotline will dispatch at least one mobile crisis team member who is adequately trained to address the crisis.

In all Regions REACH continues to be available 24 hours each day to respond to crises. There were 129 referrals included in the data the DBHDS provided about the time of day referrals were made for FY15 QII. One hundred twenty-five of these occurred on weekdays and four on the weekends. Seventy-five calls were received between 8-2; forty-three between 3PM and 8PM and four after 9PM. One hundred forty calls were received during FY15 QIII of which only one was during a weekend. Fourteen of the calls were received after 5PM including five between 9PM and 7AM.

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

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

The Regions continue to train CSB ES staff and report on this quarterly. During this reporting period only three regions provided training to CSB ES staff. The total ES staff trained during this reporting period was forty-six compared to sixty-three during the previous reporting period.

The Independent Reviewer requested a plan from DBHDS by June 30, 2014 to specify that all CSB ES personnel will be trained using a standardized curriculum and this training will be tracked. The DBHDS has developed a standardized curriculum during this reporting period and all new ES staff and case managers will be required to be trained about REACH.

Conclusion: The Commonwealth remains in compliance *with Section III.C.6.b.i.B* because the REACH programs continue to train ES staff. DBHDS has responded to the Independent Reviewer's requirement to develop a training plan in that the training is now required for all new personnel. The DBHDS continues to be unable to track if all existing ES staffs have been trained but REACH staff continues to make training available.

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

ii. Mobile Crisis Teams

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

The National Center for START Services at UNH continued to provide training to the REACH staff in Regions I and II. REACH leaders in Regions III, IV and V have worked together to develop a training program that will provide similar training for their staffs. DBHDS has reviewed and approved the curriculum for use across the three regions. The training is divided into three modules to be completed within 30, 60 and 120 days of hire. Module 1 includes orientation to the DOJ Settlement; REACH history; REACH Roles; documentation; orientation to crisis services including assessment, crisis stabilization, and crisis planning; introduction to ID, DD, Autism Spectrum and Dual Diagnosis; registration and billing; and orientation to the CTH Program including staff shadowing. Module 2 includes orientation to the ID and DD Waivers; introduction to the mental status examination; assessing/evaluating symptoms and behaviors; medication and medical overview; and long-term assessment. Module 3 includes an orientation to DM-ID; family systems conceptualization; communication and working with multi-disciplinary teams; developmental issues; positive behavioral supports; and specialty populations. The Regions will use nationally available training materials online. I briefly reviewed many of the sites and the resources are of a quality nature.

The training process includes tests to determine competencies and skills that have been learned. Supervisors are involved with staff reviewing training outcomes. Supervisors will use team meetings to reinforce the training concepts. Clinical supervision is provided in a group format. Staff will shadow community and CTH staff as part of their orientations. Staff must prepare and present case reviews and participates in peer reviews.

Conclusion: The Commonwealth is in compliance with *Section 6.b.ii.A.*
It has developed a comprehensive training program and a process to reinforce learning through supervision, team meeting discussions and peer review.

Recommendations: The REACH programs may want to include person-centered planning, discharge planning and family training in the training program.

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

The teams continue to provide response, crisis intervention and crisis planning. During the FY15 QII services were provided to 154 individuals and to 228 individuals in Quarter III. These services included crisis prevention, crisis intervention/prevention planning, crisis stabilization, medication evaluation, therapeutic treatment planning and follow up. One hundred fifty-four individuals received some or all of these services in the CTH program and ninety-one received some or all of these services through mobile crisis support in Quarter II. Ninety-four individuals were served in the CTH program and 334 through Mobile Crisis Support in Quarter III. There may be duplication in the numbers since some individuals receive both mobile support and use the CTH program. It is interesting that more services were provided in the CTH program than the Mobile Crisis Support program in the first quarter of this review and many more were served by the Mobile Crisis Support during the second quarter.

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

C. Mobile crisis team members adequately trained to address the crisis shall work with law enforcement personnel to respond if an individual comes into contact with law enforcement

REACH program trained 226 law enforcement staff during the reporting period. This training was provided in Regions I, IIII, and V. Regions II and IV did not train any police in this time period.

DBHDS has developed a work plan for Law Enforcement Outreach. The plan includes communicating with all law enforcement entities about REACH, including information about the new children and adolescent initiative; creating and disseminating printed materials; conducting regional meetings with law enforcement entities; and develop an online training module available to police officers through the Department of Criminal Justice Services website. The training will be implemented starting in July 2015. This is a very positive step.

Conclusion: The Commonwealth is in compliance with *Section 6.b.ii. C* since many officers have been trained in this reporting period and the DBHDS has a plan to insure all are trained.

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

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

As reported earlier in Section 4 the REACH Mobile crisis teams are available around the clock and respond at off hours. During the reporting period the CSB ES teams made a few referrals in Region II during QII and none during QIII. This is a sign that case managers and families have become aware of REACH services and are making referrals directly.

There were 150 mobile assessments performed during FY15 QII of which 56% were conducted in individuals' homes or day programs. Thirty-five percent of the individuals needed to be assessed in the hospital, ES/CSB, or police station (1). The other individuals were assessed at the CTH setting. During FY15 QIII there were 176 mobile crisis assessments performed of which 53% were conducted in individuals' homes or day programs. It is interesting to note that twenty-three of the referrals were made by residential programs compared to sixty-four from families during QIII. This is a significant increase over the previous Quarter during which residential providers made thirteen referrals. This may indicate that providers have a greater understanding of the benefits of the REACH program and are seeking the expertise of the REACH staff.

Forty percent of individuals were assessed at a hospital, CSB/ES or other community setting including medical clinics and crisis stabilization units. Twelve individuals were assessed while in the CTH. A number of individuals are leaving their home setting for the assessment to occur. Although this percentage is 35-40% across the two quarters very few referrals were made outside of normal business hours.

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

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

DBHDS is now collecting and reporting data on the amount of time that is devoted to a particular individual. Most regions provided individuals with more than three days on average of in-home support services with the exception of Region V in FY15 QIII that averaged 2 days. Regions provided community based crisis services as follows:

Region I*: twelve individuals or an average of seven days in QII*
Thirty-two individuals or an average of our days in QIII
Region II: *twelve individuals or an average of ive days in QII*
Fourteen individuals or an average of 3.5 days in QIII
Region III: *seventeen individuals or an average of thirteen days in QII*
Twenty-one individuals or an average of eleven days in QIII
Region IV: *thirty-eight individuals or an average of three days in QII*
Thirty-two individuals or an average of our days in QIII
Region V**:** *ourteen individuals or an average of eleven days in QII*
Thirty-seven individuals or an average of two days in QIII

Regions vary in the number of individuals served and the total number of days of community based crisis services. During FY15 QII the number of days per region varied from 59-217. The range was 49-239 in FY15 QIII. Region III provides the most mobile days totaling 456 during the reporting period. Regions IV and V provide 242 and 228 respectively and Regions I and II provide 137 and 108 respectively.

A similar pattern of disparity in the number of individual served and the number of days the community based crisis service was offered was evidence in the last two reports. This finding does not impact compliance but continues to bring in to question workload of the REACH staff. The individuals reported by mobile crisis days do not correspond to the total number of referrals per region. Region I had the most referrals: seventy-nine and Region V had the least: thirty-eight.

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

G. By June 30, 2013 the Commonwealth shall have at least two mobile crisis teams in each region to response to on-site crises within two hours
H. By June 30, 2014 the Commonwealth shall have a suf icient number of mobile crisis teams in each Region to respond on site to crises as ollows: in urban areas, within one hour, and in rural areas, within two hours, as measured by the average annual response time.

Regions have not created new teams, but have added staff to the existing teams. The added staff has not resulted in sufficient capacity to provide the needed crisis response within two hours as required. This became a more stringent requirement as of June 30, 2014 when the teams were expected to respond to requests from urban areas in less than one hour and requests in rural areas in less than two hours. The DBHDS reports that Regions II and IV are urban areas and should meet the expectation of responding to a crisis referral within one hour.

The response rates for FY15 QII are as follows:

- ✓ Region II responded to seventeen calls within one hour but is missing data for eight individuals. This is 32% of the calls the region received.

- ✓ Region IV could not respond to two (11.8%) of its seventeen referrals within one hour.
- ✓ The average response times for these regions are thirty-nine and forty-three minutes respectively.

Regions I, III, and V are rural regions that are required to respond to crises in two hours or less. These regions had a total of 111 calls that required a face-to-face response.

- ✓ Region III met this requirement during FY15 QII.

Regions I and V had a total of seven individuals (8%) out of ninety-one individuals who were not responded within two hours.

- ✓ The average response time was sixty-five minutes for Region I, seventy minutes for Region III, and seventy-two minutes for Region V.

- ✓ Approximately 94% of the referrals needing an onsite response were responded to in the required timeframes as reported by DBHDS

The response rates for FY15 QIII are as follows:

- ✓ Region II responded to forty-four calls of which four (9.1%) were not within one hour. Two took 61-90 minutes, one took 91-120 minutes and one took over 121 minutes to have a response.

- ✓ Region IV responded to fifty calls of which four (8%) were not within one hour. These four were responded to within 61-90 minutes.

- ✓ Regions I and III responded to forty-five and fourteen calls respectively. Each region had one individual who took over 121 minutes to reach.

- ✓ Region V responded to fifty-five calls of which three were responded to in more than 121 minutes.

- ✓ The on time response rate again was 94%. However Region IV and V have missing data for this quarter. Region IV is missing response time data for four individuals (8%) and Region V is missing its response data for seven individuals (13%).

I learned during the course of this review that the regions calculate the response time based on the time the team makes the decision that the referral requires a face-to-face assessment or consultation. DBHDS cannot report on the length of time it takes for that decision to be made. The purpose of establishing required timeframes for crisis response is to assist families and providers to effectively assist a person in a crisis. The acceptable timeframe of two hours is already causing REACH teams to recommend to families that they first call the police or the CSB ES team in the case of future crises. The REACH team's response can be much greater than the one of two hours expected by the Settlement Agreement depending on the length of time it takes to decide on the need for an onsite response.

I spoke with a DD Case Manager in Region I at the request of the Independent Reviewer. She has referred five individuals to REACH. She does not report that REACH responds in a timely way. One person's mother called at 8AM and the Case Manager followed up at 3:45 PM. REACH responded after 10 PM. Another referral was made on 4/25/14 and REACH responded on 5/15/14. Another individual was referred on 11/14/14. REACH called back on 11/15/14 and made a face-to-face visit on 11/19/14. I also spoke with DOJ staffs that are

conducting individual reviews. They report complaints form police about the length of time it takes for REACH Coordinators to respond to a crisis call.

Conclusion: The Commonwealth remains out of compliance with *Section III.C.6.b.ii.G.* The Commonwealth is also not in compliance with *Section III.C.6.b.ii.H*. The data indicates compliance but DBHDS cannot tell the actual length of time for responses.

Recommendations: The REACH teams are expected to respond more quickly to crisis requests from individuals living in urban areas starting in FY15. The Commonwealth did not create two or more teams in each region as the Settlement Agreement required. It instead added members to the existing team in each region. However the Commonwealth continues to be non-compliant with this requirement. DBHDS should report on the time it takes to respond to calls based on a clear standard using the time of the call and the time of arrival to determine the response time. REACH Coordinators should participate in all crisis assessments even if the assessment is led by the CSB ES so REACH staff can become involved immediately. The Court should require the Commonwealth to fund and develop additional teams or hire remote staff in Regions that continue to be unable to meet the response expectations by the end of the next review period after assessing the true response time.

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

All regions now have a crisis stabilization program providing both emergency and planned respite. All Regions have six beds available.
Region IV remains in its temporary location. I visited the CTH operated by Region IV that is in a campus location outside of Richmond. I interviewed Reba James, CTH Coordinator, Dr. Kaul, Medical Director and Christen McClanahan, the I/DD Director for the Region. There were three individuals at the CTH at the time of my visit. The CTH is located in an older residential facility. It s not located in a typical neighborhood and is larger than a normal home. The region has struggled to locate a more appropriate location over the past two years. The Independent Reviewer only approved the Brook Road facility as a temporary location for the Region IV CTH program, because of the urgent need for CTH services. The REACH team with

the input of the REACH Regional Advisory Council has found land in Chester. They have the architectural drawings that were developed with input from program staff that visited other REACH CTH homes. The Region was closing on the land purchase the week of my visit (3/31/15). The plan is to break ground in September and open by March 2016.

Table 2 summarizes the number of individuals who used the Crisis Stabilization Units during the two quarters covered by this review. The regions continue to provide both emergency and planned respite in the REACH Crisis Stabilization Units. The programs no longer report how many individuals use the program as a step down from the training schools, which was reported in the past.

There were a total of 319 visits to the CTH programs, which is the same number as the last reporting period. There were more visits for crisis stabilization (162) than for crisis prevention (157) but unlike previous reporting periods the numbers are fairly equal. It is also positive that DBHDS continues to offer planned respite in the REACH Crisis Stabilization Units for individuals at risk of crises. This type of planned respite is very beneficial to families who continue to care for their relative at home.

TABLE 2 INDIVIDUALS USING THE REACH CRISIS STABILIZATION UNITS DURING Y15 SECOND QUARTER (QII) AND Y15 THIRD QUARTER (QIII)

REGION	QII Emergency	QII Planned	QIII Emergency	QIII Planned	Total Emergency	Total Planned
I	10	10	20	9	30	19
II	8	34	11	20	19	54
III	22	13	19	13	41	26
IV	12	12	17	23	29	35
V	19	14	24	9	43	23
TOTAL	**71**	**83**	**91**	**74**	**162**	**157**

THE REACH program continues to provide community –based mobile crisis support as well. Three of the five regions were able to retain the residential setting for most of the individuals in crisis who received mobile crisis response. Region III had fifty-four individuals stay in their setting and nine use the CTH program. Thirteen individuals were hospitalized in a psychiatric facility. Region IV had thirty-five retain their setting and fourteen use the CTH. Twenty-two individuals were admitted to a psychiatric hospital; Region V had eighty-five retain their home setting and five use the CTH. Twenty-one individuals were admitted to psychiatric facilities. In these three regions fifty-six individuals were admitted to a psychiatric setting.

However Regions I and II had more individuals as a percent of those served that were hospitalized. In Region I only twenty-four retained the home setting while twenty used the CTH and an additional nineteen were hospitalized. Region II was able to support fourteen individuals to stay home while twenty-one used the CTH. However, nineteen were hospitalized. Only 56% of the individuals who received mobile crisis support were

maintained in their home. Nineteen percent used the CTH program and 25% were admitted to psychiatric facilities.

This information is based on the DBHDS quarterly reports for this review period. The 25% represents ninety-four admissions. This is a high number of individuals who could not be first served effectively through either the mobile crisis component of REACH or by using the CTH to first stabilize their behaviors. This requires further analysis to determine why the crisis response system cannot address the needs of these individuals and if there is a need for Virginia to develop additional clinical supports or specialized residential short -term settings for these individuals if the number of admissions remains high or increases. It is also important for REACH to stay involved with these individuals and their community teams to assist with discharge planning and support the work of teams during the transition back to the community.

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

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

The DBHDS is to determine if there is a need for additional crisis stabilization units to meet the needs of individuals in the target population. All of the Regions have unused bed days in both quarters of this reporting period. In FY15 QII they range from 71-392. The five regions had similar availability in FY15 QIII with a range of 71-373 unused days. Two Regions did not have anyone on the Waiting List. Region IV had four individuals on the Waiting List in FY15 QIII. Regions III and V had individuals on the waiting list in both quarters. In the fourth quarter this totaled six, and three individuals respectively. The number of individuals was not given for QII but one individual was hospitalized in Region III as a result of a lack of an opening at the CTH.

Region III plans to add one bed to its CTH at least temporarily. This will put it out of compliance with the Settlement Agreement requirement that crisis stabilization units have no more than six beds.

2015 REVIEW OF THE EMPLOYMENT SERVICES REQUIREMENTS OF THE US v COMMONWEALTH OF VIRGINIA'S SETTLEMENT AGREEEMENT

REVIEW PERIOD: OCTOBER 7,2014– APRIL 6, 2015

SUBMITTED TO DONALD FLETCHER
INDEPENDENT REVIEWER

PREPARED BY: KATHRYN DU PREE, MPS
EXPERT REVIEWER
APRIL 30, 2015

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I. OVERVIEW OF REQUIREMENTS

Donald Fletcher, the Independent Reviewer has contracted with Kathryn du Pree as the Expert Consultant to perform the review of the employment services requirements of the Settlement Agreement for the time period 10/7/14 – 4/6/15. 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 or the target population and include a term in the CSB Performance Contract requiring application of this policy; [use] the principles of employment irst include of ering employment as the irst 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 irst practices.

7.b.i. Within 180 days the Commonwealth shall develop an employment implementation plan to increase integrated day opportunities or 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, or 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 rom supported employment;

d. The number of individuals in pre-vocational services as defined in 12 VAC 30-120-211 in ef ect on the ef ective 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

1.b.i.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.

1.b.i.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 for the review period through 10/6/14 and the recommendations the Independent Reviewer made in his last Report as a result of the conclusions and findings of that review of Employment Services. At that time the Independent Reviewer determined that the Commonwealth was in compliance with: III.C.7.b.i.A, IIIC. & b. i.B.1.a, d, and e. Recommendations were made to further develop the Integrated Day Activities Implementation Plan improve the sources and validity of employment data, oversee the work of the CSBs to promote employment first, and successfully reach out to individuals with developmental disabilities.

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

- The Commonwealth's ability to meet the targets it set and the progress toward achieving the FY 2015 targets for the number of people in supported employment, those who remain for at least twelve months, and the average earnings for those in supported employment,
- The refinement of the implementation plan to increase integrated day activities for members of the target population including strategies, goals, action plans, interim milestones, resources, responsibilities, and a timeline for statewide implementation,
- The continued involvement of the SELN in developing the plan and reviewing the status of its implementation, and
- 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.

III. REVIEW PROCESS

I reviewed relevant documents and interviewed key administrative staff of DBHDS and members of the SELN to provide the data and information necessary to complete this review and determine compliance with the requirements of the Settlement Agreement. Initially a kickoff meeting was held in January 2015 with the Independent Reviewer, the Expert Reviewer, Heather Norton, Peggy Balak, Jae Benz and Adam Sass to review the process and clarify any components before initiating the review.

Document Review: Documents reviewed include:

1. Virginia's Plan to Increase Employment Opportunities for Individuals with Intellectual and Developmental Disabilities: FY2013-2015: Goals, Strategies, and Action Items
2. DBHDS Employment Plan Draft: February 2015
3. The Commonwealth's Plan to develop integrated day services including volunteer activities and community recreation
4. Employment Data
5. SELN Work Group meeting minutes relevant to the areas of focus for this review
6. Regional Quality Council meeting minutes and recommendations for implementing Employment First

Interviews: The Expert Reviewer interviewed Adam Sass Employment Services Specialist from DBHDS, members of the SELN; Connie Cochran, Assistant Commissioner for Developmental Services, and Heather Norton, Director of Community Support Services, DBHDS

Review of Individual Support Plans (ISPs): The Expert Reviewer reviewed a random sample of ISPs to determine if employment is being offered as the first option to individuals in the target population. This was accomplished by randomly selecting a sample of twenty-two individuals from the five regions that were receiving pre-vocational support, group supported employment (GSE) or individual supported employment (ISE).

IV. THE EMPLOYMENT IMPLEMENTATION PLAN

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

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

Review of Virginia's Plan to Increase Employment Opportunities for Individuals with Intellectual and Developmental Disabilities: FY 2013-FY2015- Goals, Strategies, and Action Items.

DBHDS with the input of the SELN Advisory Committee has created a plan to increase employment opportunities. I was provided with the Status Report as of 12/31/14. The Plan includes six goal areas each of which has sub-goals.

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

Status: The DBHDS, DARS and DOE efforts continue to be in the planning stages. DARS has reported to me that DOE is funding a position that can be used as an Employment Specialist in the Northern Virginia area to assist schools and ESOs to plan for transition. DBHDS is appropriating four positions to DARS to expand this initiative to other parts of the state but these are unfunded positions. The discussions among the three state agencies to undertake a initiative in a rural part of Virginia to improve employment opportunities for individuals upon high school graduation appears to have stalled. Accreditation of ESOs is still in the discussion phase. DBHDS has made progress on its data collection by using data from the ESOs. The department does plan to use DARS data as the first source of data when the next semi-annual data request is made of the ESOs. ESOs will be provided this information for its participants in the data survey and will only need to add the data for individuals that receive waiver or other funding. DBHDS continues to provide education to other state agencies. This quarter the department staff provided technical assistance to DMAS staff and formal training to DARS and DBHDS staff about current allowable employment services under the HCBS waivers.

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

Status: A Regional Summit was convened in the southern part of the state. More than 50 individuals attended it from CSBs, DARS, ESOs and advocacy groups. There is now a sub-committee of the SELN that is addressing education and training. The DBHDS plans to convene at least three Regional Summits in 2015. The sub-committee has also developed curriculum based on the ARC of VA's training on Self-Advocacy and Employment. There is no progress noted on the sub-goal to reach out to businesses to educate and increase awareness of employing individuals with disabilities.

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

Status: The DBHDS is making progress with its waiver redesign that will provide the necessary underpinnings for a more robust set of employment services and supports that provides incentives for employment. The Status Report indicates the SELN Advisory Group (AG) has had an active part in this re-design but SELN AG members report a lack of meaningful involvement in this process wit the exception of some cross over in membership between the SELN AG and the Waiver Design Advisory Committee (WDAC). One of the sub-goals is to lead and support providers in increasing their capacity to provide community-based employment. There is no tangible progress on the one activity for the SEL AG and DBHDS, which is to develop standards for the delivery of employment. There isn't any plan to build provider capacity that is recognized as being needed in more rural areas of Virginia.

Goal 4: Financing and contracting methods within and across agencies to support community-based employment service delivery.

Status: DBHDS and DARS are making progress to use DARS and HCBS waiver funding appropriately to offer individuals seamless transitions from one funding source to the other. However DBHDS and DARS need to develop protocols to use when DARS does not have funding to authorize for new individuals seeking employment supports to clarify the ESO providers responsibilities. The two departments evidence progress to address the employment needs of individuals transitioning to the community from the training centers. Training center and DARS staff in northern Virginia were co-trained during the quarter.

Goal 5: Virginia will have a system wide data collection and performance measurement system and procedures for employment data for people in supported employment.

Status: One of the indicators for this goal is to have the SELN AG and Regional Quality Councils (RQC) review the employment data and targets quarterly. Each RQC met twice during this review period. Employment was discussed at each of the meetings and the committee members had in-depth dialogue with the DBHDS staff that attended. The Presentations were thorough and most of the RQC's made recommendations for improvement. These include:

1. Work with special education programs so that they use the transition period from school to adult employment services to best prepare students to work upon graduating. (HPR4)

2. Use mentors. (HPR1)
3. Incentivize mentors on the job. (HPR1)
4. Work more closely with the school systems. (HPR 1)
5. Set an expectation that 30% of individuals have employment readiness goals in their Individual Service Plans (ISP) (HPR1)
6. Develop a transition process from Day Support Services to work to respond to the DBHDS plan to eliminate pre-vocational services from the HCBS waivers. (HPR 4)
7. Collect data regarding why individuals with ID do not want to work. Include this as a question in the proposed Quality Service Reviews. (HPR 3)
8. Initiate a quality improvement initiative to address regional lack of transportation for individual placement. (HPR 3)
9. Educate families about the benefits of employment and the impact of employment on individuals' benefits. (HPR 3)
10. Educate case managers on employment including discussing employment with individuals and including employment related goals in the ISP. (HPR 3)
11. Utilize public service announcements to provide education about individuals and employment. ((HPR 3)
12. Create a statewide data system to collect employment data. (HPR 3)

Many of these recommendations mirror the employment plan that has been developed by DBHDS. It would be beneficial to review Virginia's Plan to Increase Employment Opportunities for Individuals with Intellectual and Developmental Disabilities: FY2013-2015- Goals, Strategies and Action Items with the RQC's and provide progress reports about implementing the plan. The RQC members could then make recommendations for any additional specific actions they believe should be added to the existing plan to further the employment goal of increasing the number of individuals who are competitively employed. The recommendations of the RQC's are being shared with the SELN AG during the committee's April meeting. The SELN members will be asked to add recommendations they feel will improve the Commonwealth's efforts to meet its targets.

SELN members complain that the employment target data has not been reviewed with the full AG. The data sub-committee has reviewed it. Other members report not having this presented at meetings that occurred during this review period. DBHDS plans to review the targets and the employment data at the April meeting of the SELN AG. The SELN should have regular opportunity to review this data and use it to guide their activities and policy recommendations to DBHDS.

I address the other indicator regarding the availability of data to guide the planning and quality improvement process for employment services under Section V: Setting the Employment Targets.

Goal 6: Virginia's SELN Advisory Group will have a formalized structure with clearly defined roles and responsibilities for members.

Status: DBHDS has provided significantly improved structure for the SELN Advisory Group during the past six months. Sub-committees have been created to address policy, education and training, employment data and membership. In addition DBHDS has created a separate

advisory group to address integrated day activities, now referred to as community engagement, with its own sub-committees. Minutes are taken at all meetings. The Membership sub-committee has recommended that membership be reduced so that all stakeholder groups have similar representation. DBHDS is following up on this recommendation. Letters are being sent to the various stakeholder groups that have representatives on the SELN directing them to select and confirm their representatives by July 2015. It is expected that the number of SELN members will be reduced and that attendance will be more consistent.

Conclusion and Recommendations: DBHDS is in compliance with provision *7.b.i.A* that it provides regional training on the Employment First policy and strategies. However I continue to recommend that the administration determine how best to share this information with families and report in the future on its outreach to this groups specifically. DBHDS does plan to engage youth and families through youth and family summits throughout the next year. The purpose is to continue to hear from these stakeholders even though their representation on the SELN will be reduced, as will all other groups. The DBHDS should include summaries of these summits and the number of individuals who attend during future reporting periods. DBHDS continues to make progress implementing its employment implementation action plan. Outreach should include specific strategies to reach the DD community.

7.b.i.B.1.a-e: The Commonwealth is to develop an employment implementation plan to increase integrated day opportunities or individuals in the target population including supported employment, community volunteer activities, and other integrated day activities. The plan shall establish, or individuals receiving services through the HCBS waivers:
Annual baseline information regarding:
a. The number of individuals receiving supported employment;
b. The length of time people maintain employment in integrated work settings;
c. The amount of earning rom 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 changed its data source and the data it is collecting about individuals who are employed and those who are in sheltered work. The data that I have reviewed in the past has been admittedly faulty. It did not address all of the requirements of the Settlement Agreement. It could not account for individuals entering and temporarily leaving employment so may have over or underreported both data elements. Most notably it did not include wage data or the number of hours individuals work. The DBHDS worked with the SELN to determine an approach to regularly collect more accurate data. DBHDS does not have its own database for individuals who participate in employment services through the HCBS waivers. DARS does have employment data for individuals it funds. The SELN AG advised the department to collect this data directly from the Employment Service Organizations (ESO).

The DBHDS conducted a pilot to determine the feasibility of collecting the data using this method. Four providers participated and found it relatively easy to collect the data. DBHDS made revisions to the data collection tool from the feedback of the pilot participants and with

the input of the SELN AG. The SELN data sub-committee took on the task of designing the data collection tool with the DBHDS. The plan is to collect this information semi-annually. The first full survey was sent out in October 2014 to be returned by December 1, 2014. There are sixty-three ESOs in the Commonwealth. Responses were received from twenty-eight for a response rate of 44%. DBHDS estimates that the data represents 70% of the number of individuals served by ESOs given the proportionate number of individuals in employment services that are supported by the ESOs that responded. All of the information below is based on the results of this survey so it is not fully inclusive of all individuals with ID or DD who are engaged in SW, GSE or IE.

Average hours worked- DBHDS can now provide information on this data element. Individuals who have an ID work an average of 19 hours per week. Individuals who have a DD work an average of 20 hours per week. The range for individuals with DD is 13 hours per week in Region III and 23.5 hours per week in Region II. The range of hours worked per week for individuals with ID is 14.6 in Region I- 23 hours per week in Region II. This information is aggregated for ISE, GSE and SW.

DBHDS did break it out to report on the hours worked by individuals in IE. Individuals with ID who work independently work an average of 23.4 hours per week and individuals with DD work an average of 23.5 hours per week. The range of hours worked for both groups is the same: 13-33 hours per week. Region III has the lowest average of 13 hours and Region II has the highest average of 33 hours for both groups.

Average length of time at current job- the average length of time for individuals with ID at their current jobs is ten years and for individuals with DD the average length of time is eight years. The number of years worked ranges from 3-17 for individuals with ID and 2-28 for individuals with DD. Region V data skews the average considerably. In Region V individuals with ID have been in their jobs seventeen years on average. Individuals with DD have held their jobs for twenty-eight years on average. This may be because it reports significant long-term contractual work. The other four regions range from 3-13 years for ID and 2-3 years for DD. These averages are influenced by the length of time individuals have worked who are in sheltered work. This information was also reported specifically for individuals who are in IE. Individuals with DD in this category have worked an average of 1.45 years and individuals with ID have worked 4 years on average. The range is 1.04-2.10 for individuals with DD and 2.05-7.06 years.

Earnings from supported employment- DBHDS collected information regarding wages and earnings. This information has not been available before and the department is to be commended for its efforts to respond to this requirement. DBHDS has data for 1650 individuals with ID and 254 individuals with DD as a result of this survey. Wage information was provided for 1332 of the 1650 individuals with ID (80%) and for 148 of the 254 individuals with DD (61%). The data portrays the following about the wages for these individuals:

- ✓ 840 individuals with ID (63%) are paid minimum wage or above
- ✓ 116 individuals with DD (78%) are paid minimum wage or above
- ✓ The average wage for ID individuals is $5.85
- ✓ The average wage for individuals with DD is $6.60

Subsequent to the DBHDS Semi-Annual Report on Employment the SELN Data Sub-Committee did further analysis. This analysis indicates that:

- ✓ 490 individuals with ID earn less than the minimum wage ($2.48 average)
- ✓ 1160 individual with ID earn minimum wage or more ($9.19 average)
- ✓ 32 individuals with DD earn less than minimum wage ($3.82 average
- ✓ 222 individuals with DD earn minimum wage or more ($8.42 average)

Only four individuals with ID that are in IE are earning less than minimum wage. No one with DD in IE earns less than minimum wage.

Individual Employment- the number of individuals enrolled in IE was 200 individuals at the time of the Fall 2014 Review. The number reported in the December 2014 employment survey totals 821 individuals who have an ID and 179 individuals who have a DD. This is a far more significant number of individuals than have been previously reported. This is because this is the first time DBHDS has been able to collect information on employment that reflects all sources of funding: DARS, HCBS Waivers, CSB and other sources. This is the new baseline so understandably it does not include the number of individuals who started employment during this reporting period. This includes only people who are actually working and being paid.

Group Supported Employment- the number of individuals that participate in GSE totals 688, of whom 625 have an ID and 63 have a DD. The number enrolled in GSE at the time of the Fall 2014 Review was 687.

Pre-Vocational Services- the number of individuals in Pre-vocational services is 216. This includes 204 individuals with ID and 12 individuals with DD. This represents a reduction since the last report. During the last reporting period it appeared that 286 individuals were in Pre-Vocational Services for twelve to thirty-three months, subtracting the numbers of individuals who newly enrolled and those who discontinued services. Individuals with ID have been in these services between 4 and 14 years. Individuals with DD have been in Sheltered work between 5 and 11 years. Only three regions have individuals with DD in SW.

Conclusion and Recommendations: The DBHDS is not fully in compliance with *7.b.i.B.1.a, b, c, d, or e.* because it can only report on 70% of the population. This is a new data source that is far improved from previous data collection. DBHDS can now report on earnings and the length of time individuals have been employed. It is not possible to determine if DBHDS is making progress towards enrolling more individuals in IE because this new data creates a new baseline. It is extremely positive to have data that includes all individuals with ID and DD that are employed rather than a report that was limited to those individuals who are employed using HCBS waiver services only. DBHDS now has more accurate data about both the ID and DD populations related to employment. It is encouraging that GSE and SW do not appear to be increasing in the number of individuals who participate in these employment options.

I applaud the efforts DBHDS has made to collect and report more accurate data. However it is a concern that the department is relying on the ESOs to report and has made this reporting voluntary. Only 44% of ESOs responded to the survey. This data is not complete unless

DBHDS requires reporting and achieves 100% compliance. DBHDS reports it plans to work with DARS to continue to refine the data collection methodology including the possibility of electronic submissions in the future. I fully support these plans. The DBHDS needs to require all ESOs to provide employment data.

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

V. SETTING EMPLOYMENT TARGETS

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

The targets depicted in ***Table 1*** are for the total number of individuals in IE for each of the next five fiscal years.

Table 1 EMPLOYMENT TARGETS OR Y15 – Y19

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

Increasing the number of individuals in IE: The targets in ***Table 1*** reflect the targets set by the DBHDS in March 2014. These targets were based in the information available from the HCBS waiver data. The DBHDS plans to revise these targets based on more comprehensive data that indicates 1,000 individuals in Virginia who have ID or DD are in individual employment. DBHDS plans to use the national average that 25% of individuals with ID and DD who participate in employment services. The plan is to include the number of adults now on the HCBS waivers (11,000) and those on the waiting list (4,500) many of whom may be receiving DARS services to determine the universe of individuals seeking day support or employment. The DBHDS is working with the SELN AG this spring to establish new targets. The target will be increased significantly from the previous target of 1661 individuals by FY19. However these targets will now include individuals in both IE and GSE who are working and earning at least minimum wage.

Individuals in Supported Employment The current goal is to reach 85% of the total number of individuals in IE who remain employed for 12 or more months. I suggest the DBHDS maintain this target goal and collect data that allows them to report on the length of time individuals are employed through IE separately from individuals in GSE or Pre-vocational services.

Conclusions and Recommendations: Compliance with Section *7.b.i.B.2.a and b* cannot be determined based on the new data and the need to create new targets as a result of more meaningful and comprehensive information about this population.
The Commonwealth is reporting may more individuals who are employed. It can now report on individuals with ID and DD separately. I suggest it develop separate targets for each of these groups and continue its new practice of reporting on each group separately. The DBHDS should also determine its targets separately for individuals in IE and for those in GSE to insure its decision to pursue an Employment First Policy is implemented as intended. Currently 57% of the individuals with ID who are employed are in IE and 43% are in GSE. Seventy-four (74%) percent of individuals with DD are in IE versus 26% that are in GSE. DBHDS should not reduce the percentages it expects should be independently employed when it sets its new targets that will include both GSE and IE.

In order for the Commonwealth to reach these targets the DBHDS will need to concentrate its efforts on completing its waiver redesign plan to address employment service definitions and revise its rate structure, focus on building provider capacity, and further train all case managers in the Employment First policy and the principles of person-centered planning to help individuals and their families identify and pursue their employment goals and aspirations. Provider capacity is going to be critical to the success of meeting these targets. The number of individuals in IE in Regions II, III and IV is very small with Region II reporting only sixteen individuals.

I continue to recommend that the Commonwealth further refine these targets by indicating the number of individuals it hopes to provide IE to from the following groups: individuals currently participating in GSE or pre-vocational programs; individuals in the target population who are leaving the Training Centers; and individuals in the target population who become waiver participants during the implementation of the Settlement Agreement. 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 SELN to reach out to families, Case Managers, CSBs, Training Center staff, and ESOs to assist the DBHDS to achieve its overall targets in each of the next five fiscal years.
The Commonwealth is in compliance with III.C.7.c and d. It discusses the targets and the progress towards implementing the employment services plan with the Regional Advisory Councils quarterly and insures the input of the RACs is shared with the SELN AG. Members of the SELN AG that are also employment leads in DBHDS meet with the RACs.

VI. THE PLAN FOR INCREASING OPPORTUNITIES FOR INTEGRATED DAY ACTIVITIES

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

Waiver Redesign: The Commonwealth is continuing its planning efforts to redesign its waivers serving individuals with ID and DD is undertaking a significant redesign of its HCBS waivers. The new waiver application will include a definition for integrated day activities and revise the definition of supported employment, restructure the rates for waiver services and redesign the implementation of the SIS as it is used as an initial assessment tool and an indicator of the individual's level of need for support. Various work groups have been convened to assure broad input from stakeholders. The SELN had some input into the definitions of supported employment but was not formally linked to the waiver redesign work group. The SELN did develop the definition for integrated day activities. The Commonwealth plans to submit its new waiver design in early FY16 for implementation in late FY16.

The Waiver design elements align the intensity of need of the individual with resource allocation. Providers will need to be qualified and also demonstrate the necessary competencies to serve individuals with more complex needs. DBHDS plans to have basic and enhanced rates to promote the use of integrated day activities that rely on more intensive staffing patterns at least for periods of time until the individual can more regularly use natural supports and their community connections. The waiver will include the option of consumer –directed services and will utilize an individual budgeting methodology as currently conceptualized.

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

Since the Commonwealth of Virginia entered into the Settlement Agreement with the US DOJ, DBHDS has focused its work and activities on increasing employment opportunities for individuals with ID and DD. With rare exception providers in Virginia still do not offer individuals who are not employed other types of integrated day activities. DBHDS was directed by the Independent Reviewer to develop a plan by March 31,2014 describing its approach to create integrated day activity capacity throughout its provider community and ensure that individuals in the target population can participated in these integrated activities as the foundation of their day programs.

The Commonwealth was not in compliance with *7.a.* as of the last review (October 2014). I recommended at the time that the DBHDS determine how it will assess the need for these services; determine the policy for continuing congregate day services; how teams will be trained in person-centered planning to introduce this service option; train CSBs, ID, and DD Case Managers; assess and plan to expand capacity; qualify providers.

DBHDS developed its Integrated Day Activity Plan on July 2014, which was the basis for my review in October 2014. This report indicated the DBHDS would convene a meeting by mid-October and submit a full plan by December 2014. I was provided the DBHDS Community Engagement Plan Draft: February 10, 2015 and the Quarterly Update (2/23/15). The Plan has five goals:

1. Developing a common understanding and philosophy.
2. Policy review and alignment with philosophy.
3. System transformation for the implementation of Community Engagement Activities.
4. Implementation of best practices in the provision of Community Engagement Activities.
5. Monitoring to ensure implementation.

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. The SELN has developed a robust definition of Integrated Day Activities now called Community Engagement that will be used to define this service type in the new waiver. The definition the plan offers of integrated day activities assures they are meaningful, offered at times to benefit the person to have an active community-based daily routine, including community education or training, retirement, recreation and volunteer activities. The definition is outcome focused. Integrated day activities must be offered in the community, facilitate the development of meaningful relationships wit typical individuals, and facilitate community inclusion. Transportation is included that will be a key element to successfully offering these services. The DBHDS is to be commended on developing this comprehensive definition of integrated day activities.

Since the last report, DBHDS has established the Community Engagement Advisory Group with two sub-committees to address policy and training and education. The sub-committee has begun to develop training modules for all stakeholder audiences. The service definitions have been shared with the Waiver Design Advisory Committee (WDAC) for inclusion in the waiver amendments that will be submitted to CMS.

Burns and Associates have developed the rates for these services. This is the firm that is contracted to develop the rates for the waiver redesign. There is a proposed rate structure for Day Support Community Access (Community Engagement) and Day Support Community Services. The rate development is part of the waiver redesign and the original plan indicates that funding will be addressed by the General Assembly if funding increases are needed in March 2015. The DBHDS will not make its funding request until the new waivers are approved by CMS. DBHDS has not done any projection of how many individuals will want or need this service. It is a more costly service than the existing day habilitation model due to staffing ratios and transportation so it is difficult to understand how it could be offered without targeted funding.

The Plan includes a section on System Transformation with a long range goal of: "structures, at both the state and provider level, will support delivery of Integrated Day Activities in the least restrictive and most integrated settings appropriate to the specific needs of the individual as identified through the person-centered planning process." Positively it includes statewide training for providers, families, individuals and other stakeholders; the development of a guide book, ensuring providers can provide the necessary supports,

develop provider interest in delivering integrated day activities and work with education agencies to discuss this option during transition planning. All of these occur between March 2015 and January 2016. This area still needs greater specificity in the plan. It does now address the need to educate CSBs and ID/DD Case Managers.

DBHDS has decided that it will offer individuals the consumer-directed option for Community Engagement Activities. I think this is a very positive step by DBHDS. The option provides individuals and their families with the choice and flexibility they deserve and will expand the capacity of the system to meet this need for a larger number of individuals. It is setting a goal to have 40% of individuals on waivers engaged in their communities by October 2017.

DBHDS has not started and of the work associated with Implementation or Monitoring. The 2-23-15 Quarterly Review states that work on Implementation will not begin until the new waiver is implemented.

The revised plan does not specifically address:

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

Conclusion and Recommendations:
The Commonwealth is not in compliance with *III.C.7.a.* It does not have a comprehensive implementation plan and it still is unable to offer its consumers integrated day activities. However it is troubling that the Commonwealth does not plan to offer this service across the system until FY16 when the new waiver is implemented. The most recent timeline for the waiver redesign anticipates the response from CMS in February 2016. Then DBHDS needs approval and funding from the General Assembly. This will support implementation of the waivers in July 2016 at the earliest. Individuals will be able to initiate new services as their individual review of the ISP occurs. This indicates many individuals will not have the opportunity for integrated day activities until calendar year 2017. The Commonwealth committed to this endeavor in 2012 as a result of the Settlement Agreement. I remain concerned that the Commonwealth will not start this service for more than four years since the agreement was signed.

My recommendations remain the same from my last report. In order to be successful by that time the DBHDS must develop, more specific plans as to how it will work with the current provider network to prepare them to implement Community Engagement Activities and with the CSBs and Case Managers to introduce this service concept into the person-centered planning process. These are critical elements of a successful service delivery system and need to be planned for now if new services are to be in place and communicated to individuals by July 2016. I recommend the DBHDS develop a much more detailed implementation plan with

timelines and report specific actions semi-annually. An explanation should be given for any timeline that is missed. I further recommend that the DBHDS set targets to assist them to achieve the goal of having 40% of waiver participants engaged in Community Engagement by October 2017.

The Independent Reviewer may want to seek an order from the Court for the Commonwealth to submit a specific plan that includes an assessment of need, the number of individuals it will serve in each remaining year of the Settlement Agreement, and a funding request to the Legislature for each of those years for the identified number of individuals. DBHDS reports that it has developed a tiered system to determine individual's needs for support to participate in Community Engagement for general budgeting purposes. It should use this as the foundation to develop a needs assessment for determining the full extent of resources that will be needed to implement this model effectively. The DBHDS continues to neither offer integrated day activities to individuals with ID/DD nor has a specific implementation to do so.

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) or 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 of ering employment as the irst and priority service option; providing integrated work settings that pay individuals minimum wage; discussing employment options with individuals through the person-centered planning process at least annually.*
- ✓ *Employ at least one Employment Services Coordinator to monitor the implementation of the employment irst practices.*

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

ISPS That Include Employment: Part of this review is to determine if the expectation that individuals in the target population are offered employment as the first option by Case Managers and their teams during the individual planning process in which they discuss and develop employment goals. I have reviewed a random sample of ISPs. I requested the list of all individuals in the following groups who are part of the target population: individuals already in Individual Employment (IE), Group Supported Employment (GSE) or Pre-Vocational Services who had an annual ISP meeting during the reporting period. Lists were provided to me from the five regions and I randomly selected a total of twenty-four individuals. I requested the most recent ISP, vocational assessments and any relevant progress notes. I received documents for twenty-two of the twenty-four individuals I requested but I could not open one person's file.

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

1.Has the Case Manager and planning team discussed the availability of employment supports with the person and the guardian?
2.Has the Case Manager determined the individual's interest in employment and asked what type of job he or she would prefer or choose?
3.Are there one or more employment goals that are related to the person's interests and will assist the person to achieve independent community-based employment?
4. Has there been a discussion of the initial steps the team needs to take to assist the person to become employed?
5.Has a vocational assessment been requested and conducted if the individual, guardian or team recommends it?
6.Has the Case Manager made referrals to employment service providers if the individual is interested in supported employment?

I reviewed the records provided. In some cases they were not complete especially regarding the vocational assessment. This was a similar issue in the Fall 2014 review. I reviewed a total of twenty-one individuals including: seven in pre-vocational services, two in ISE and twelve in GSE. The summary of the answers to the questions is provided in *Table 2* on page 21. Out of the entire group Case Managers have discussed the availability of individual employment supports with only five of the twenty-one individuals. Case Managers learned of the individual's interest in working for seven of the individuals but pursued a discussion about the type of job the individual might want with only four of the individuals. Vocational assessments were only present or referred to for six individuals. There was no discussion about the initial steps to be taken to assist the person to be employed with anyone in pre-vocational services or with any individuals in GSE settings. No one was referred for individual employment even those with a strong interest.

Some additional themes emerge from the individual reviews. When the person is asked about their preferences and interests in work there does not appear to be a detailed discussion, any real probing nor does it naturally lead to a discussion of the steps the team should take to assist the individual to prepare for and find employment. This is consistent with my review of eighteen records during the Fall 2014 Review. Individuals state they "like to work" or "like to earn money". Often the conversation stops at that point or if it continues is not documents in the ISP. When individuals say they are satisfied with what they are doing there is no discussion about what they like about their job or task and to what types of employment these interests and satisfaction may lead.

The CSBs by contract are to report on the engagement of the Case Managers with individuals regarding employment opportunities and employment planning. The Performance Contract with the CSBs has been modified for FY15 and 16 to more specifically require reporting. The contract's Exhibit B- Performance Measures require the CSB to report quarterly regarding the discussion of integrated community based employment during the ISP meetings and those who have employment related goals in their ISPs. The DBHDS Semi-Annual Report on Employment includes a section entitled Tracking Employment First Conversations. DBHDS

reports on data from the CSBs for the time period 7/1/14-12/31/14. There were a total of 4848 adults whose case managers conducted annual ISP meetings or updates between 7/1/14 and 12/31/14. The report indicates that the case managers discussed integrated community-based employment and that 1526 have employment or employment related goals in their ISPs. This results in a statewide average of 77% having an employment discussion and 31.5% having an employment or an employment related goal.

My findings concur with individuals having a discussion about their employment interests (31.5%% from CSB reports and 33% from my individual reviews). My findings vary considerably from the CSB reporting regarding the discussion of employment. I reviewed the records to determine if there was documentation of an actual discussion of the employment first initiative and the state's efforts to provide individuals with the opportunities to seek and find employment for suitable wages. I found this evidence in only 24% of the records reviewed and this included two individuals who were already employed. If there was only a discussion of the individual's current work situation and satisfaction with it and the individual was in a pre-vocational program or GSE, I did not determine this met the expectation that DBHDS has set for the CSBs and their Case Managers.

DBHDS is requiring a new format for the ISP that is to be implemented with plans developed or revised after April 1, 2015. Training if CSB staff and providers has been initiated. The format places greater emphasis on employment and should guide the discussion between Case Managers, individuals, families, and other team members. I would expect to see an improvement next fall in the individual reviews of employment.

TABLE 2 SUMMARY OF INDIVIDUAL REVIEWS FOR EMPLOYMENT
Number of Indicators met by program category and overal percentage

Question	Pre-voc	GSE	ISE	% MET
Employment discussed	0	3	2	**24%**
Employment interests	0	5	2	**33%**
Employment Goal	2	3	2	**33%**
Initial Steps	0	0	N/A	**0%**
Vocational assessment	1	4	1	**29%**
Referral for ISE	0	0	N/A	**0%**

Conclusion and Recommendations: The Settlement Agreement requires the Commonwealth to ensure that individuals in the target population are offered employment as the first day service option. DBHDS includes this requirement expectation in its Performance Contracts with the CSBs for FY2015 and FY2016. My review of this small sample of ISPs continues to validate the need for more formal communication and direction to the CSBs from DBHDS.

The CSB Performance Contract for FY2015 and 2016 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.

From the small sample of ISPs I reviewed there is no indication that CSBs are in compliance with the Performance Contract regarding employment planning for members of the target population or with the requirement to include employment related or readiness goals in the ISP.

CSBs are now reporting on these measures and DBHDS provides a summary of the findings by region in its most recent Semi-Annual Report on Employment. This is positive but DBHDS still needs to report on how they will analyze, monitor and follow up on these reports. What will be done to assist the CSBs to meet these expectations? What is the benchmark that DBHDS will use to determine compliance and progress? They should issue guidance to the CSBs on the expectations of these two contractual provisions so there is accurate and consistent reporting.

The DBHDS still does not monitor the employment first requirements with DD Case Managers. They should develop a similar review process for the ISPs that DD Case Managers develop for individuals with DD who are not served by the CSBs.

The Commonwealth is not in compliance with *III.C.7.b.* It is positive that DBHDS has revised the performance reporting requirements for the CSBs for the current and future fiscal years and that the CSBs have started to report this information. Quarterly reporting by the CSBs will provide DBHDS with accurate and current information about the implementation of Employment First. DBHDS needs to establish its own quality review protocol to analyze these reports and have a follow up strategy to work with any CSBs that are not in compliance. Corrective strategies should be required and there need to be consequences if progress is not achieved. DBHDS needs to set the same requirements for DD case Managers and monitor these expectations.

The Engagement of the SELN: The VA SELN Advisory Group was established to assist DBHDS to develop its strategic employment plan, set the targets for the number of individuals in the target population who will be employed, and provide ongoing assistance to implement the plan and the Employment First Policy. This past year input was sought from SELN AG members to revise the definitions of employment services and to define integrated day opportunities which are also required as part of the Settlement Agreement. The VA SELN AG

includes self-advocates, family members, advocacy organization members, CSB staff, state agency administrators, educators, and employment providers. The VA SELN AG was established in 2008.

I interviewed nine members as part of the review of Employment Services in 2013 and the Spring of 2014.The interviews included representatives of CSBs, educators, families, advocates, self advocates, state agencies and providers. In light of concerns interviewees expressed about the operation of the SELN and the group's ability to have meaningful input into the employment planning process I chose to interview as many of the same members as were available for this review. I asked all of the members interviewed about the operation of the SELN and the opportunity for input into the DBHDS planning process; target setting; training for case managers; the development of the plan for integrated day services; and outreach to the DD community.

The SELN AG remains active in its advisory capacity to DBHDS regarding its employment initiative. I have reviewed the minutes of the meetings of the SELN and its sub-committees and interviewed nine members who represent a variety of stakeholders.

1. ***The operation of the SELN and the opportunity afforded its members to have input into the planning process.*** All members who I interviewed report that the SELN is making progress. They appreciate the organization and structure that Heather Norton and Adam Sass have brought to the committee during the past six months. Members report that the SELN is better able to adhere to it agenda and move discussions so that actions can be discussed and implemented. The SELN now has several sub-committees to address membership; data; policy; interagency efforts; and education and training. There is better notice of the meetings and members appreciate the efforts by the SELN chairpersons to use Doodle to efficiently determine dates and times of committee meetings. Members would appreciate receiving documents that relate to the agendas ahead of time to provide ample time to review these materials prior to the meetings.

The Membership Committee has recommended that the SELN reduce its membership. This is being done to achieve a better balance in the number of representatives for all stakeholder groups. DBHDS is sending a letter to each stakeholder group that is represented on the SELN to request that each group select a member who will serve a its representative on the SELN. DBHDS anticipates having this membership change in place by the end of the summer. The members that I interviewed believe this will bring greater consistency to attendance and will support the SELN's efforts to focus on recommendations and decision-making. The DBHDS has made a commitment to use the Family and Youth Summits to continue to seek input from broader stakeholder groups.
The members are also positive about the department's decision to create a separate advisory group to address the plan for integrated day activities/integrated community. This committee has also formed sub-committees to address policy and education and training issues relate to this initiative.

2. ***Improving employment data***-The SELN AG has had significant input into the department's initiative to improve the data it has about employment including wage and hour data that has been unavailable during earlier reporting periods. The Data Committee had input into the survey that was sent to the Employment Service Organizations (ESO) and have made suggestions to improve the clarity of future surveys. Generally members report this is a good first step to improve the employment data that can be used to review and revise employment targets.

Members are concerned that DBHDS only received completed survey from 28 of ESO providers. The members support the department's plan use DARS data in addition to the information provided by the ESOs. There is also data required by contract with the ESOs that the CSBs collect on hours worked and wages paid. The members want the data to be as accurate as possible and used for to make policy and strategic planning decisions. This issue is discussed in greater detail under the section of the report on the employment targets.

3. ***Employment Service Planning***- The DBHDS has made a decision to include the consumer – directed option for integrated day activities. The department has not yet decided if this option will be available to individuals who pursue employment under the HCBS waiver. The members who support this believe it provides individuals with another avenue to become successfully employed. Members who do not support it worry about the qualifications of the staff and their ability to complete the documentation that is required under the waivers. I recommend that the State seriously consider including consumer directed employment in its waiver amendments. It provides individuals with appropriate choice and much greater flexibility to use their networks to secure employment. Other states include this option for their waiver participants. DBHDS could adopt and/or revise the approaches used by other states to set staff qualifications and to define documentation requirements.

Some members express concern about the current transition from DARS to HCBS waiver service authorization and view it as an impediment to ESOs supporting individual supported employment. DARS and DBHDS worked together to develop a smooth transition process that would engage the Case Manager but that would be seamless for the individual and family. It is reported that DARS cannot currently fund additional individuals with I/DD for employment support. DARS is the first and primary funder for employment support and is expected to provide the funding needed initially for assessment, job development and job placement. Individuals transition to the HCBS waivers after the funding from DARS is fully utilized. SELN members express concern that ESOs will not use waiver slots first for individuals who cannot receive DRS funding because they are concerned that they will be expected to pay back these funds when they are audited. There is also the unanswered question of the provider's responsibility when DARS funding is once again available. Providers are uncertain if they are expected to transfer the individual from HCBS funding to DARS funding and then back to HCBS funding when the DARS funding has been exhausted. This is a potential barrier to employment for individuals with ID or DD. DBHDS is addressing this on an individual basis when it is brought to the department's attention. However, it needs to be addressed in policy and procedure so that all ESOs can address the funding issue in a consistent manner.

4***. Training***-The DBHDS recently provided training to providers in the new format of the ISP, which among other changes highlights employment to support Case Managers to engage in a meaningful discussion about employment as part of the annual planning process. This is a positive step. There was concern that in parts of the state the training was only offered a week before the CSBs and providers were expected to use the new ISP format.

5. ***Reviewing the employment targets and waiver redesign plans***- SELN AG members report that DBHDS has not engaged them in the review of the targets. DBHDS plans to review this information with the SELN AG during April. SELN members have provided input to the WDAC regarding the definitions of services related to employment. There is a crossover of some members but SELN members report that DBHDS does not formally share information on the progress of the WDAC or if the committee has adopted the recommendations of the SELN.

6. ***Review of the Community Engagement Plan***- DBHDS has created a second Advisory Committee to provide recommendations regarding the implementation of the plan for Community Engagement Activities. All members who were interviewed think this is a positive step. The AG now has input into policy and education and training. This allows the SELN AG to devote its time and energies to the implementation of the Employment Plan.

7***. Interagency Initiatives***- the initiative shared in the last report has not been planned. This was to create collaboration among DARS, DOE and DBHDS to work with a rural school district to improve the employment readiness of its students. DARS is hiring an employment specialist in northern Virginia using funding from DOE to expand support for school to work transitions. DBHDS is transferring four positions to DARS for the same purpose but these will require new funding before employees can be hired.

Members have made specific suggestions for DBHDS to consider:

- Consider regional planning resources for the employment initiative so that plans and implementation reflect local differences that impact employment
- Apprise the SELN and stakeholders of the changes being proposed for the waiver amendments and the status of submitting the waiver amendments to CMS for review and approval. The SELN has had limited input into the waiver redesign and has not received consistent feedback on the WDAC's consideration of these ideas
- Initiate conversations with providers to direct them on the preparation to become community integration providers building on the successful general presentations that DBHDS staff have made

Conclusion and Recommendation: The DBHDS continues to meet the Settlement Agreement requirements to maintain the SELN, but is not in overall compliance with *III.C.7.b.* It does not comply with the requirements to share employment as the first day service option using a person-centered process nor is it yet holding the CSBs accountable for the related requirements in the CSB Performance Contract. It is positive that the DBHDS is strengthening the requirements of the CSBs to offer employment first to participants but it needs to demonstrate that it is holding them accountable to be fully compliant.

The DBHDS should continue to work collaboratively with the SELN, implement the new membership plan, and include them in a more meaningful way in the review of reaching the employment targets and other employment initiatives.

VII. SUMMARY

DBHDS is in compliance with Sections:
III.C.7.b.i.A
III.C.7.b
III.C.7.c
III.C.7.d

DBHDS is not in compliance with Sections:
III.C.7.a
III.C.7.b
III.C.7.b.i.B.1.a, b, c, d, e

Compliance cannot be determined for Sections:
III.C.7.i.B.2.a, b

DBHDS has made significant gains during this reporting period in its data collection. It remains concerning that there is no availability of integrated day activities, Community Engagement, for individuals on the HCBS waivers.

I recommend that the Independent Reviewer consider if immediate action needs to be required of DBHDS by the Court to finalize the implementation plan for Integrated Day Activities and to provide these activities to some number of individuals using state funding until the new waiver is available.

APPENDIX E

INDIVIDUAL AND FAMILY SUPPORTS

and

GUIDELINES FOR FAMILIES SEEKING SERVICES

By: Rebecca Wright, MSW, LCSW

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

INDIVIDUAL AND FAMILY SUPPORTS, and

GUIDELINES FOR FAMILIES SEEKING SERVICES

By

Rebecca Wright, MSW, LCSW
Consortium on Innovative Practices
May 1, 2015

I. EXECUTIVE SUMMARY

The Settlement Agreement in U.S. v. Commonwealth of Virginia requires the Commonwealth to create an Individual and Family Support program for ndividuals with intellectual and developmental disabilities (ID/DD) whom the Commonwealth determines to be the most at risk of institutionalization. The Report of the Independent Reviewer, dated December 8, 2014, found the Commonwealth had met the quantitative requirement for the IFSP by supporting the required number of ndividuals and families n FY 2014, but noted that certain qualitative requirements had not yet been reviewed, including 1) the good faith effort to determine who is most at risk of institutionalization, and 2) whether the current program and other family supports provided under the Agreement fulfill the requirements for ndividual and family supports. The purpose of this review was to make a determination as to the compliance status of the qualitative requirements found n Sections II.D, III.C.2, III.C.8.b and IX.C of the Settlement Agreement. Overall, the Commonwealth was not yet in compliance with any of these requirements.

Section II.C defines individual and family supports as a comprehensive and coordinated set of strategies designed to ensure that families who are assisting family members with ID/DD or individuals with ID/DD who live independently to have access to person-centered and family-centered resources, supports, services and other assistance. Thus far, DBHDS has focused on the development of an Individual and Family Support Program (IFSP) as a means of providing a modest monetary award to at least the number of individuals and families that is required in the Settlement Agreement, rather than on an approach that identifies gaps in current services and plans to ensure access to, and coordination of, comprehensive person-centered and family-centered resources, supports, services and other assistance. While the financial assistance available under the IFSP is certainly of some benefit to those fortunate enough to be selected to receive funding, it is essentially a one-time award rather than a comprehensive array of ongoing supports needed by individuals and families for community living. It also does little to address these needs in a coordinated manner. The current process does not include a deliberate review of whether the supports requested may be currently available to the individual or family without the IFSP funds, or assess other unaddressed needs.

The definition of individual and family supports stipulates that such supports are to be targeted to ndividuals not already receiving services under HCBS waivers, specifically the ID and IFSDD waivers; and that an individual and family support program be created for individuals with ID/IDD whom the Commonwealth determines to be most at risk of institutionalization. DBHDS has addressed these requirements by defining presence on the ID or IFSDD waiver waitlist as the sole criterion for making the determination that someone is most at-risk for nstitutionalization and therefore potentially eligible to receive a monetary award limited to $3,000 per fiscal year under the IFSP.

The philosophical and practical bases for these decisions about who is "most at risk for institutionalization" have not been well documented or communicated, nor have stakeholders had significant nput n the ongoing discussion. Overall there is a level of discomfort with this basis for distribution of funding. There was a universal uneasiness expressed among all ten non DBHDS stakeholder interviewees as to whether the design of the IFSP may be inherently unfair to those who may need t the most. For example, a common concern expressed was that the needs of ndividuals and families on the waitlists varied dramatically and there was no prioritization based on individual situations that may seem more important or urgent than others. At this point in time, there are approximately 9,800 individuals on those waiting lists. Based on the experience of the program thus far, with 1300-1500 applications funded annually, the program can only be accessed by a relatively small percentage (approximately 15%) of those who would potentially be eligible.

The Commonwealth has, as required n Section III.C.8.b, published guidelines for families seeking intellectual and developmental disability services on how and where to apply for and obtain IFSP services. It has also published fact sheets ("Just the Facts") for individuals/families with ID and IFSDD waiver slots. Section III.C.8.b also requires that published guidelines be updated annually and provided to appropriate agencies for use in directing individuals in the target population to the correct point of entry to access services. Appropriate agencies, such as Community Service Boards, advocacy organizations such as the Arc of Virginia and agencies providing private case management have been notified via email of the availability of the IFSP guidelines on-line via email and in various public meetings. The most recent update of the IFSP guidelines in February 2014 does not accurately represent some of the changes that have been made to the program methodology. Accessibility for individuals and families was limited by the level of language used and by the lack of general availability to them other than on the Internet. Both of these factors affect accessibility for individuals and families depending on their literacy needs, ncluding Internet literacy. The individual review study found that none (0%) of the twenty-three individuals with DD, other than ID, and their families reported being aware of the Individual and Family Support Program. All had been on the IFDDS waitlist when the IFSP program was initiated.

It is clear that DBHDS has engaged in a good faith effort to address an aspect of the individual and family support program requirement n its development of the one-time monetary award program and by mplementing it with urgency to meet the timeline required. On the other hand, this effort to begin the program quickly has backfired to the extent that it was not based on a focused and system c needs assessment or mplemented as part of an overall plan to ensure that its individual and family support program provided comprehensiveness or coordinated supports. As an example, the first come-first served funding prioritization process has resulted in significant backlog in the IFSP office and lengthy delays in the actual disbursement of funds. A core tenet of providing person-centered and family centered supports is input from the individuals and families. A formalized avenue for stakeholder

input s needed to help to guide the evolution of individual and family supports as a comprehensive set of strategies n the Commonwealth, and of the IFSP n particular as a part of that overall set of strategies. This lack of stakeholder involvement in the ongoing process may have contributed to a sense of frustration that appears to be growing among families and advocates interviewed for this study.

DBHDS has acknowledged its awareness of the concerns described in this report and has recently nitiated a task force to address many of them. DBHDS should prioritize stakeholder participation n both the design and implementation of individual and family support programs. It should identify the information needed to adequately assess individual and family support program's performance, impact and outcomes; and it should collect and analyze data regarding program performance versus ndicators of the proper mplementation of Sections II.D, III.C.2, III.C.8.b as required by Section IX.C.

II. PURPOSE OF THE REVIEW

The purpose of this review was to make a determination as to the compliance status of the qualitative requirements of the Settlement Agreement as they pertain to individual and family supports. These requirements are as follows:

> **Section II.D:** *Individual and amily supports are defined as a comprehensive and coordinated set of strategies that are designed to ensure that families who are assisting family members with intellectual or developmental disabilities ("ID/DD") or individuals with ID/DD who live independently have access to person-centered and amily-centered resources, supports, services and other assistance. Individual and family supports are targeted to individuals not already receiving services under HCBS waivers, as defined in Section II.C.*

The family supports provided under this Agreement shall not supplant or in any way limit the availability of services provided through the Elderly or Disabled with Consumer Direction ("EDCD") waiver, Early and Periodic Screening, Diagnosis and Treatment ("EPSDT"), or similar programs.

> **Section III.C.2:** *The Commonwealth shall create an individual and amily support program or individuals with ID/DD whom the Commonwealth determines to be most at risk of institutionalization…*
>
> **Section III.C.8.b:** *The Commonwealth shall publish guidelines or amilies seeking intellectual and developmental disability services on how and where to apply or and obtain services. The guidelines will be updated annually and will be provided to appropriate agencies or use in directing individuals in the target population to the correct point of entry to access services.*
>
> **Section IX.**C: *The Commonwealth shall maintain suf icient records to document that the requirements of this Agreement are being properly implemented and shall make such records available to the Independent Reviewer or inspection and copying upon request and on a reasonable basis.*

Specifically, the study analyzed whether both the design and implementation of the IFSP and other ndividual and family supports fulfill the requirements set forth n these sections, using the following ten criteria:

1. Whether the design and implementation of the IFSP and other ndividual and family supports provided under the Agreement result n a set of strategies that can be considered comprehensive in nature.

2. Whether the individual and family supports provided under the agreement are coordinated with other services and supports for which a family or individual may be eligible.
3. Whether the design and implementation of the individual and family supports adequately facilitate access to person-centered and family-centered resources, supports, services and other assistance.
4. Whether the design of the IFSP provides a clear and sound definition of "most at risk of institutionalization," or whether the definition has been refined to reflect the priority of supports to those at greatest risk.
5. Whether the design of the IFSP provides a clear and logical process, ncluding prioritization criteria, for determining which individuals may be considered "most at risk of institutionalization," and, if so, whether the process and prioritization criteria are implemented in a manner that s designed to address the risks of ndividuals who are most at risk of institutionalization.
6. Whether data has been collected and any trends analyzed to determine whether the IFSP s fulfilling the Commonwealth's obligations under the Agreement, and whether the Commonwealth is maintaining sufficient records to demonstrate that the provision is being properly implemented.
7. Whether the Commonwealth published IFSP guidelines as required and updated as needed, at least annually.
8. Whether appropriate outreach and dissemination processes were undertaken to ensure that individuals and families had access to the IFSP guidelines on a timely basis.
9. Whether the Commonwealth identified the "appropriate agencies" and whether such agencies were provided with the IFSP guidelines on a timely basis.
10. Whether the published IFSP guidelines were sufficient, n terms of detail, accuracy and accessibility to the population, to be effectively used to direct individuals n the target population to the correct point of entry to access services.

III. STUDY METHODOLOGY

In order to ascertain the status compliance for each of the criteria, the study methodology included components of document review, DBHDS staff interviews, stakeholder interviews, and review and analysis of available data. The document review process included requests made to DBHDS for any Workgroup and Project Team minutes, reports and any other work product related to the design of the IFSP; any needs assessment, data or nformation used in the design of the IFSP; IFSP Guidelines and administrative rules; IFSP application, instructions and any related protocol; any tools or processes used to assess individual and family assessment of and/or satisfaction with IFSP, including any reports, analyses or summaries of individual and family satisfaction; any reports or summaries of actions taken by

IFSP staff to assist ndividuals and families to access supports from other paid or unpaid sources, ncluding supports requested that did not meet IFSP funding criteria; a summary and copies of complaints, appeals and/or grievances from ndividuals and families related to the IFSP; and, any other records the Commonwealth maintains to document that the individual and family supports provided under the agreement are being properly mplemented, ID and DD Wait List criteria and process. A full list of documents reviewed may be found in Appendix A.

The data review included requests for any data collected by DBHDS on the categories of services and supports requested and funded; any data collected by DBHDS on applications made and applications funded by individuals living independently vs applications made and applications funded by families; any data collected by DBHDS on other services and supports received by individuals and families making application for IFSP; any data collected by DBHDS regarding the geographic distribution of IFSP funds; any data collected by DBHDS on individual and family assessment of and/or satisfaction with IFSP; and, any data collected by DBHDS to determine f its definition of who is most at risk of nstitutionalization can be improved and whether the pattern of fund distribution s managed to help avoid institutionalization for individuals with ID or DD, and any data to indicate that individuals/families on each waiver are aware of, and utilizing, the IFSP. Some of these data were not currently available as they were either not being collected or were not organized in a manner as to lend tself to aggregat on and analys s. A complete l st of data prov ded and reviewed is included in Appendix A.

The expert consultant interviewed DBHDS staff involved n the development and design of the IFSP, DBHDS staff responsible for day-to-day administration of the IFSP; stakeholders with knowledge of the development of the IFSP; and a broad array of stakeholders ncluding individuals and families and representatives of advocacy organizations and service organizations. The Independent Reviewer also held a Focus Group3 with individuals and families on the IFSDD waitlist to obtain their nput on individual and family supports and the design and implementation of the IFSP. This nput also informed this report. A full list of individuals interviewed is included in Appendix B.

IV. FINDINGS

Background

The concept of ndividual and family supports in the field of ntellectual and developmental disabilities, and the development of such programs n states across the country, began n earnest in the last two decades of the twentieth century. While approaches and program characteristics varied from place to place, there were certain principles, which were commonly accepted, as fundamental. As a backdrop to the discussion that follows, it may be useful to articulate several of those key tenets as they also form the basic criteria by which the concept of person and family-centeredness, a requirement of the Settlement Agreement, is defined.

- *Individuals and amilies know best what supports they need.*
- *Supports should be broadly defined and flexible, and include, but not be limited to inancial assistance, information and referral, peer support and amily support groups.*
- *Individual and amilies must be empowered to have a say in the design and implementation of systems intended to support them.*

If, as the Settlement Agreement indicates, the purpose of a "comprehensive and coordinated set of strategies" is to ensure that families or individuals have access to person-centered and family-centered resources, supports, services and other assistance, then comprehensiveness and coordination will best be judged from the perspective of these individuals and families. Therefore, progress toward the achievement of a comprehensive and coordinated set of strategies must build in a feedback loop that includes gathering the perspectives and recommendations of individual and families to improve the design and implementation.

Despite some limited outreach activities, the process undertaken by the Commonwealth thus far in developing its approach to individual and family supports in response to the Settlement Agreement has not consistently provided for such a feedback loop. In April 2012, DBHDS gathered a stakeholder group to consider and provide input on the Commonwealth's planned approach to individual and family supports, specifically to assist in design decisions regarding the implementation of the IFSP. DBHDS provided documentation of three meetings of this Workgroup, held respectively n April 2012, April 2013 and May 2014. The deliberations and considerations were not well documented on a consistent basis, particularly n terms of the options considered and the rationales for each decision. DBHDS staff acknowledge that original design decisions were made quickly, within a short time period to meet the Settlement Agreement timeline and to get funds to ndividuals and families n need as quickly as possible.

There has been no other ongoing formalized avenue for stakeholder input to help identify gaps n the comprehensive and coordination of current strategies or to help guide the evolution of individual and family supports program, or the IFSP n particular, to meet the

def n t on n the Settlement Agreement. S nce ts ncept on, ongo ng changes to the IFSP processes have been made with hopes of streamlining the program and reducing response times but these have not been consistently vetted with the work group, or other stakeholder body, in order to ensure they adequately address the issues and concerns.

This lack of stakeholder involvement in the process may also have contributed to a sense of frustration that appears, based on interviews held for this study and described further below, to be growing among families and advocates.

Compliance Findings for Section II.D:

> *Individual and family supports are defined as a comprehensive and coordinated set of strategies that are designed to ensure that families who are assisting amily members with intellectual or developmental disabilities ("ID/DD") or individuals with ID/DD who live independently have access to person-centered and amily-centered resources, supports, services and other assistance. Individual and amily supports are targeted to individuals not already receiving services under HCBS waivers, as defined in Section II.C.*
> *The family supports provided under this Agreement shall not supplant or in any way limit the availability of services provided through the Elderly or Disabled with Consumer Direction ("EDCD") waiver, Early and Periodic Screening, Diagnosis and Treatment ("EPSDT"), or similar programs.*

1. **Does the design and implementation of the IFSP and other individual and family supports provided under the Agreement result in a set of strategies that can be considered comprehensive in nature?**

Funding through the IFSP should be viewed as only one component of a comprehensive individual and family support program that includes other resources: other financial resources, peer supports, family to family support, information and referral, etc. While the financial assistance available under the IFSP s certainly of some benefit to those fortunate enough to be selected to receive funding, it is essentially a one-time award that can do little to address, n a comprehensive manner, the needs of ndividuals and families without consideration of other ongoing supports available to support community living. Otherwise, there were few concrete strategies in designing the IFSP to complement, or to coordinate with, other available supports. The only significant exception was the allowance for funds to provide additional supports to individuals, and their families, who are served under the EDCD Waiver, the Day Supports Waiver and the Technology Assisted waiver, all of which provide some services, usually at a lower intensity overall than would be available under the ID or DD waivers.

Overall, the IFSP does not include adequate design, or program evaluation, strategies to make progress toward achieving the overall goal of a comprehensive and coordinated set of strategies for individual and family support. There has been no assessment of individual and family supports available statewide or any goals, objectives and timelines for developing a comprehensive and coordinated set of strategies. There has also been no evaluation of whether the IFSP has made progress toward achieving a "comprehensive and coordinated set of strategies."

2. Are the individual and family supports provided under the agreement coordinated with other services and supports for which a family or individual may be eligible?

From a systemic perspective, coordination with other services and supports for which a family or individual may be eligible has not yet been fully realized for individuals on the ID and IFSDD waitlists and their families, and the role of case management in facilitating this access and coordination of individual and family supports, and the IFSP in particular, has not been adequately examined. The Settlement Agreement defines functions of case management, including assisting the individual to gain access to needed medical, social, education, housing, nutritional, therapeutic, behavioral, psychiatric, nursing, personal care, respite, and other services, all of which may be components of individual and family support, depending on the individualized situations. If the overall objective of providing individual and family supports is, as the IFSP Guidelines suggest, to support the continued residence of an individual with ID/DD in his/her own home or family home, then case management of the sort described above is essential to coordination of various services and supports that would be needed beyond a one-time monetary award.

Individuals on the ID and IFDDS waitlists are assigned a case manager with a frequency of required contacts ranging from 30 to 90 days, depending on individual circumstances. For individuals on the ID or DD waitlist who are receiving no services from other waivers, such contacts are not required to be face-to face meetings. Stakeholders reported in interviews that there is significant variability in the level of such assistance being provided to individuals on the waiver waitlists. This was reported to be most particularly for those on the IFSDD waitlist, which is consistent with the less intensive requirements for face-to-face case management for those individuals and their families.

As it pertains specifically to the IFSP, there is not a role for case managers defined in the IFSP Guidelines, nor is there any indication in the IFSP application or instructions that guide individuals and families to their assigned case manager for any needed assistance. DBHDS provided training to IFSDD case managers prior to this last round of funding, in January 2015, but again stakeholders reported some case managers take a more active role in notifying individuals and families of the opportunity, providing an application and/or providing guidance and assistance to those who need help with completing the application process. In

an Individual and Family Support Focus Group held by the Independent Reviewer with individuals and families on the IFDDS waitlist in March 2015, approximately 25% were not aware of the IFSP. The Independent Reviewer's study of twenty-three individuals with DD, other than ID, and their families found that none (0%) reported being familiar with the ISFP while they were on the IFSDD waitlist. While this is of note, data provided by DBHDS for FY 2014 indicated that 18% of funded applications were for individuals on the IFSDD waitlist, a figure which is consistent with the ratio of the ID waitlist vs. the IFSDD waitlist and would appear to indicate access to funding is equitable in that regard. Data for the other years would be needed to draw a clearer conclusion, however.

The number of applications for the IFSP has grown between FY 2013 and FY 2015, from 1,744 to 5,500, an increase of 315%. The amounts requested also ncreased during that sme period from $2,303 to $2,500. (from 77% to 83% the maximum allowed). Current IFSP staffing resources are not sufficient to meet the turnaround goals set for handling and responding to applications before the most recent volume ncrease in the number of applications. These same staff resources cannot support the identification of other available resources and coordinate with other agencies for each application it receives.

Families and advocates nterviewed by the independent consultant consistently indicated frustration over the lack of transparency about the IFSP processes and perceived lack of responsiveness from IFSP at DBHDS

The IFSP Program Director from the first year of its operation reported she was able to do some such coordination nformally n the first funding period, informing individuals and families of additional resources for their requested supports and facilitating contact. Current IFSP staff indicated in response to document review that some ndividuals were referred to DARS for respite grant funds, but no other coordination information was available.

3. Does the design and implementation of the individual and family supports adequately facilitate access to person-centered and family-centered resources, supports, services and other assistance?

As ndicated above, systemic coordination of person-centered and family-centered resources, supports and services does not appear to be consistently available to individuals on the waitlists and their families at this time. Other design and implementation factors also limit access, particularly related to the first-come first-served processes. Since the initiation of the IFSP, the volume of applications has grown as ndividuals and families have become more aware of the program. In FY 2014, there were 1,539 applications received and 1,300 (84%) were funded. In the first funding period for FY 2015, 3,300 applications were received, but only 600 (18%) were funded. A second FY 2015 funding period opened on March 31, 2015, and by April 14, 2015, approximately 2,000 applications had been received according to IFSP

staff. It would appear that the number of FY2015 applications would have at least tripled the , from 1,744 to 5,500, an increase of 315%. The amounts requested number received n FY2014. There has also been a steady trend toward requests for a higher dollar amount, as represented on the table below.

	Applications Received	Applications Funded	Percentage Funded	Total Funds Expended	Average Dollars per Application
FY 2013	1,744	825	47%	$1.9 million	$2,303
FY 2014	1,539	1,300	84%	$3.2 million	$2,461
FY 2015 (First Funding Period)	3,300	600	18%	$1.5 million	$2,500
FY 2015 (Second Funding Period To Date)	2,000	TBD	TBD	TBD	TBD

Table 1: IFSP Funding Data by FY (Fiscal Year)

IFSP staff report that individuals and families are ncreasingly requesting the maximum $3,000 amount of funding with ncreasing frequency. Families are allowed to select among several various broad categories and have a full twelve months to expend the allotment. In the most recent funding period, they also have had more flexibility to make unilateral adjustments to the original ntended purpose for the funds, as long as the expense is among the approved potential expenditures. This trend may result in serving fewer individual and families, if the first funding period of FY 2015 is any indication.

Families and advocates nterviewed for this study also consistently ndicated frustration over a lack of clarity and transparency about the IFSP processes and perceived lack of responsiveness from IFSP staff at DBHDS. This was the most frequent concern expressed across stakeholder interviews. There were many descriptions of frustrations experienced by the interviewees and the stakeholders they represent, including:

- Individuals and families are unable to find out the status of an application for many months, including both whether it had been received, funded or not funded.
- Individuals and families were requested in this fiscal year to delay asking for summer camp funding until the second funding period, but notifications of award were to begin on July 1. By that t me, most camp spots were l kely to be f lled, and t was not feas ble to make deposits n the hopes of receiving funding in time, since reimbursement of that deposit is not allowed under the current guidelines.

- In some instances, notifications of award status were never received.
- There were changing expectations and due dates without adequate notice or explanation
- Erroneous information, such as the incorrect zip code on the most recent application form

A Special Review of the Individual and Family Support Program, conducted by the DBHDS Office of Internal Audit, dated July 11, 2014, recommended that timeline goals be set for completion of application review and appropriate notifications. Management response at that time, as noted in the audit document, was that the turn-around goal was 30 days between receipt of an application and submission of check requests to fiscal for processing, with 10 workdays allowed for check processing. This timeframe s considerably shorter than the current target dates described above. IFSP staff stated in nterviews conducted for this report that those proposed timeframes were unachievable given available staff resources and the growing volume of applications.

Compliance Findings for Section III.C.2.

> *The Commonwealth shall create an individual and family support program or individuals with ID/DD whom the Commonwealth determines to be most at risk of institutionalization. In the State Fiscal Year 2015, a minimum o 1000 individuals supported.*

4. Does the design of the IFSP provide a clear and sound definition of "most at risk of institutionalization," and has the definition has been refined to reflect the priority of supports to those at greatest risk?

The "most at risk for institutionalization" requirement of the SA has been defined by DBHDS in a very broad manner. Presence on either the ID or IFDDS waiver waitlist is the sole criterion for making the determination that someone is most at-risk for institutionalization and therefore eligible to receive a monetary award under the IFSP. This broad definition s in keeping with the primary tenets of the traditional ndividual and family support programs that all individuals with ntellectual and developmental disabilities and their families need and deserve supports and that they should not have to prove they are somehow more deserving than someone else.

While most stakeholders appear to agree with this n principle, the philosophical and practical bases for these decisions have not been well documented or communicated, nor have stakeholders had ongoing input n the discussion to feel a level of comfort with the distribution of funding. There is an almost universal uneasiness among stakeholder interviewees as to whether the design of the IFSP may be inherently unfair to those who need it the most. A common theme expressed was that the needs of ndividuals and families on the waitlists varied dramatically and there was no prioritization based on individual situations

that may seem more "important" or urgent than others. For example, there was some uneasiness expressed as to whether summer camp or violin lessons should be funded over health and safety-related needs.

The waitlist criteria for the ID and IFSDD waivers require only that individuals have diagnoses and needs that would necessitate the level of care provided in an institution if an appropriate community living environment were not otherwise provided. The ID waitlist is further stratified into "urgent" and "non-urgent," but this differentiation is not factored in to the determination of most at risk or any prioritization. On its face, this lack of most at risk prioritization between urgent and non-urgent appears to be contradictory.

There was a perception expressed among those interviewed that many more individuals were seeking to be placed on the IFSDD waitlist, in order to be eligible for IFSP funding, who might otherwise be in a relatively stable living situation that did not place them at imminent risk for institutionalization. This is a consideration as it relates to whether such individuals are relatively most at risk. While it was not possible within the scope of this project to make an assessment of why the IFSDD wa tl st has grown, t had expanded at a more rap d pace than the ID waitlist. Between June 2013 and April 2015, the DD waitlist grew from 1,300 to 1,885, a rate of 43%; during that same period the ID waitlist grew from 6,672 to 7,939, a rate of only 19%.

Each of these issues should be weighed carefully as the Commonwealth develops a comprehensive plan for individual and family supports. There are arguments to be made on all sides, none of which is outside the bounds of the general principles upon which individual and family supports were originally founded. Factors to be considered should include the requirements of the Settlement Agreement as well as the consensus of stakeholders' perspectives regarding the significant gaps in comprehensiveness and coordination.

5. **Does the design of the IFSP provide a clear and logical process, including prioritization criteria, for determining which individuals may be considered "most at risk of institutionalization," and, if so, whether the process and prioritization criteria are implemented in a manner that is designed to address the risks of individuals who are most at risk of institutionalization.**

The Administrative Code related to the IFSP (§37.2-203) and the IFSP Guidelines, updated February 2014, do not provide any prioritization criteria for further determining which individuals may be most at risk for institutionalization beyond the requirement for being on the waitlist for either the ID or IFSDD waiver. No assessment of level of need or current status as it relates to imminent risk of nstitutionalization s completed in the application review process. Instead, the Code and Guidelines stipulate only that applications submitted by individuals and families will be considered on a first come-first served basis.

APPENDIX A: DOCUMENT/DATA REVIEWED

1. Settlement Agreement Implementation Structure
2. Initial creation and invite of IFSP Workgroup April 2012
3. IFSP Meeting Notes 4-27-12
4. IFSP Meeting Notes 4-27-12-1.
5. Individual and Family Support Proposed Regulations-draft-5-7-12
6. Workgroup and Project Team minutes and reports for April 3, 2013 and May 15, 2014
7. DBHDS Individual and Family Support Program Guidelines, updated February 1, 2014
8. IFSP Administrative Code (Virginia Administrative Code, Title 12. Health Agency 35. Department of Behavioral Health and Developmental Services, Chapter 230. Operation of the Individual and Family Support Program
9. IFSP Application and Instructions, FY 2015
10. Revised IFSP Application and Instructions, March 2015
11. DBHDS IFSP PowerPoint presentation, dated 7-10-13
12. Email to CSBs re: notification of IFSP applications to be mailed, June 16, 2014
13. Arc Webinar on IFSP Flyer, 2-14-14
14. Article for VA Board for People with Disabilities for their newsletter/website in December 2012
15. Virginia Lifespan Respite Voucher Program Application and Reimbursement Procedures
16. IFSP PowerPoint presentation to DD Case Managers January 2015
17. FY 15 Proposed Process Adjustments for IFSP (Feb 2014)
18.
19. ID Wait List criteria and process (http://easyaccess.virginia.gov/waiver-mrid.shtml#whatmakes)
20. IFSDD Wait List criteria and process http://easyaccess.virginia.gov/waiver-ifdds.shtml#whatmakes)
21. http://www.dbhds.virginia.gov/individuals-and-families/developmental-disabilities/community-support-services
22. IFSP 2014 Data regarding # received FY 14
23. 2014.05.15 - Individual and Family Support Program FY 13 – 14 Denial data
24. 2014.05.15 – Approved item details for FY 2014
25. FY 2014 Final All IFSP Application 7-2-2014
26. FINAL FY 2014 All accepted applications 7-2-2014
27. Family Appeal Letter, dated 2-9-14
28. 2014 Assessment of Disability Services in Virginia, Virginia Board for People with Disabilities
29. BRBH FAMILY SUPPORT PROGRAM GUIDELINES