

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

United States District Court for  
Eastern District of Virginia

Civil Action No. 3:12 CV 059

October 1, 2016 – September 30, 2017

Respectfully Submitted By

A handwritten signature in blue ink, appearing to read "Donald J. Fletcher", is written over a light blue horizontal line.

Donald J. Fletcher  
Independent Reviewer  
December 13, 2017

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## **I. EXECUTIVE SUMMARY**

This is the Independent Reviewer's eleventh Report on the status of compliance with the Settlement Agreement (Agreement) between the Parties to the Agreement: the Commonwealth of Virginia (the Commonwealth) and the United States, represented by the Department of Justice (DOJ). This Report documents and discusses the Commonwealth's efforts and the status of its progress and compliance during the review periods from October 1, 2016 to September 30, 2017.

The Independent Reviewer reported previously that the Commonwealth's various regulations and its Home and Community Based Services (HCBS) Waiver programs had impeded its compliance with provisions of the Agreement. On September 1, 2016, the federal Center for Medicare and Medicaid Services (CMS) approved the Commonwealth's redesigned HCBS Waiver programs for individuals with intellectual and developmental disabilities (IDD). The Commonwealth's goal for its redesign is to *"provide for a flexible array of community-based options with a rate structure that supports the cost of new and existing services and provides incentives to providers for offering expanded integrated options."* The Commonwealth has not yet approved revisions to its DBHDS Licensing Rules and Regulations.

The Commonwealth redesigned its HCBS Waivers with new and/or revised eligibility criteria, service definitions and expectations, payment rates, service limits, and cost caps. Once approved, implementation has required extensive statewide systemic changes, training and communication, all of which must continue to achieve the goals of the redesign. In the coming year, the Commonwealth plans to add to its array of services that support integrated day opportunities. It also will prepare applications to renew two Waivers. These renewal applications will provide the Commonwealth an opportunity to update its quality improvement plan to be current with its developing quality management system. Putting the redesigned system in place will require an ongoing and multi-year effort. As of June 30, 2017, however, substantial changes were clearly evident. DBHDS had issued 183 licenses to providers to increase opportunities for individuals to participate in community engagement services and it had approved 1,708 authorizations for individuals to receive either Community Engagement or Community Coaching. This trend continued with 1950 such authorizations as of September 30, 2017. This substantial increase in the number of individuals participating in new integrated community-based day services is evidence of both the considerable interest among individuals and families and the demonstrated ability of providers to respond to their interests.

The impact of the redesigned Waivers will occur more slowly in several areas, including on the available array of integrated residential service options. Due to the Commonwealth's housing development initiatives in recent years, however, changes are emerging in the residential options now available. A higher percentage of the individuals who transitioned from Training Centers are moving to smaller homes of four or fewer individuals. The DBHDS provider development efforts will continue to result in more smaller group homes. The Commonwealth has created 553 additional independent housing options. The 2015 Low Income Housing Tax Credit set-aside units have been constructed and are becoming available. In addition, the sponsor homes reviewed have provided strong supports for individuals, including those with complex needs.

The DBHDS Licensing Regulations have long been, and continue to be, an obstacle to substantial progress toward compliance with many provisions of the Settlement Agreement. The Commonwealth understands the problem; it has been drafting revisions to the OLS Rules and Regulations for several years, while it has been exploring other mechanisms. The Commonwealth has revised some of its regulations to align, where possible, its monitoring and investigation systems with the requirements of the Agreement. Its licensing regulations continue, however, to restrict the Commonwealth from requiring submission of information or attendance at trainings related to developing the required quality and risk management processes. Its most recent draft revisions to the Licensing Regulations, dated July 17, 2017, show an improved alignment with some provisions of the Agreement, including a clarification of expectations around root cause analysis, risk triggers and thresholds, risk management programs and quality improvement programs. This most recent draft, however, does not include criteria that align with the Agreement's requirements for enhanced case management, case manager/support coordinator responsibilities at face-to-face meetings, and an assessment of the "adequacy of individualized supports and services." It is the Independent Reviewer's considered opinion that, without revisions to its Licensing Rules and Regulations, the Commonwealth will continue to be unable to make substantial progress toward implementing the required quality and risk management system. For example, the Commonwealth has not yet informed the CSBs and other providers of its requirement that they implement risk management processes, or its expectations regarding their roles and responsibilities to contribute to a system to "adequately address harm and risks of harms."

Although the Commonwealth cannot make substantial progress toward compliance without making needed revisions to its licensing regulations, the DBHDS, Division of Quality Management and Development (DQMD) staff are doing important, necessary and appropriate groundwork that will be beneficial over the long-term. During the tenth and eleventh review periods, the DQMD staff:

- Expanded and improved its ability to collect and analyze consistent, reliable data;
- Defined relevant measures for each "domain";
- Outlined a new course on how to identify and address risk;
- Improved the mortality review data collection, analysis, and the quality of reviews; and
- Implemented a thoughtful approach with subject matter experts to evaluate data elements for accuracy, completeness and usefulness.

It is important to note that effective implementation of the Quality and Risk Management provisions of the Agreement are crucial to fulfilling the goals of addressing harm and risk of harm and improving service quality. The Commonwealth is in the midst of making substantial changes in complex service systems. During such periods, effective quality improvement and risk management programs are essential to learn what is, and is not, working as expected as well as what revisions are needed. Risk management programs ensure that harm and risks of harm are adequately addressed. Changes in new programs and settings, like all transitions, involve new opportunities and, frequently, new risks. It is the considered opinion of the Independent Reviewer that the Commonwealth will not be able to accomplish major advances toward achieving compliance without changes to the DBHDS Licensing Rules and Regulations.

The data reported by DBHDS and the findings from studies by independent consultants have shown that the overall performance of the Community Service Boards has not made substantial progress toward fulfilling provisions of the Agreement. By adding terms to its Performance Contract with the CSBs, the Commonwealth assigned them responsibility for fulfilling many of the Agreement's requirements, including case management, crisis services, and some of the Quality and Risk Management provisions. During the past three years, the CSBs have not made sufficient progress in offering a choice of service providers, including of case manager annually; developing and discussing employment services and goals; submitting timely referrals to the Regional Support Teams; assessing the individual's previously "unidentified risks ... or other changes in status" or "assessing whether the individual's support plan is being implemented appropriately." For the Quality and Risk Management provisions, overall, the data submitted by the CSBs have not been reliable. The CSBs have not implemented and reported data through risk management systems, as required. Data reporting that the overall performance of CSBs is below standard may result from a subset of CSBs whose performance, as currently measured and reported, is consistently below standards. The Commonwealth's Performance Contracts with CSBs do not appear to have improved CSB performance as reported.

The Commonwealth utilizes the CSBs' twenty-four hours per day Emergency Services, including CSB hot lines. The CSBs, through various collaboration models, operate the Commonwealth's crisis services and the REACH programs for children and adults. During the period of the REACH programs being developed and becoming more fully operational, there has been a significant increase in the number of children who are assessed at hospitals and admitted to state psychiatric facilities. The CSB and REACH protocols contribute to increased hospitalizations by completing assessments after most individuals have been transported to hospitals. This adverse outcome indicates that the crisis planning and prevention strategies have not prevented individuals with IDD from being removed from their home settings.

The Individual Services Review study found two previously identified problems that have persisted under the redesigned Waivers. Families of individuals with IDD, who live at home, were not able to hire or retain nurses or direct support professionals to provide essential supports, especially in more rural areas. Many families, especially of individuals with intense medical and behavioral needs, could not fill support hours that the Commonwealth had approved as needed to address an essential service. Family members frequently reported that the people who are qualified will not work for such low hourly pay, especially given the extra costs of travel and the extended commuting time in rural areas. Many families whose family members' behaviors were not under control could not find a qualified behavior specialist. For those who receive behavioral services, the elements of the behavior programming provided did not meet generally accepted standards.

The Commonwealth has worked diligently, has made substantial improvements, and for the first time, gained a determination of compliance for its development of independent housing options and for improving and implementing its Community Engagement Plan to increase integrated day opportunities. For independent housing, the Commonwealth has created 553 units of independent housing and is a year ahead of its planned schedule to create 847 additional units by 2021. For integrated day opportunities, having gained CMS approval of its redesigned Waivers, the Commonwealth improved its implementation plan; clarified the roles, involvement and expectations of both DBHDS and the CSBs; completed extensive training with families, providers, and case managers; approved 183 new licenses; and authorized 1950 individuals to participate in Community Engagement and Community Coaching services, two new integrated day options.

Although, compliance was not achieved, the Commonwealth made notable progress in other areas as well. Examples include:

- Improved medical services, especially in the more densely populated areas (i.e., Tidewater). Mobile crisis teams responded to more crisis calls, from children and adults, and did so within the average response required time of one or two hours, for urban and rural areas, respectively.
- Crisis Stabilization Homes (i.e., Crisis Therapeutic Homes) were made available to more individuals by reducing length-of-stays in excess of the maximum allowed thirty-days.
- Regional Support Teams helped to reduce barriers and to locate more integrated options, when it received referrals in sufficient time to identify and address barriers.
- The Offices of Licensing and Human Rights implemented increased supervision, look-behind protocols, 45-day follow-up visits and/or focused studies, which strengthened the effectiveness in their oversight functions.

The following “Summary of Compliance” table provides a rating of compliance and an explanatory comment for each provision. The “Discussion of Compliance Findings” section includes additional information to explain the compliance ratings, as do the consultant reports, which are included in the Appendix. The Independent Reviewer’s recommendations are included at the end of this Report.

During the next review period, the twelfth, the Independent Reviewer will prioritize monitoring the status of the Commonwealth’s compliance with the requirements of the Agreement in the following areas: the status of the Commonwealth’s creation of 325 Community Living Waiver slots in Fiscal Year 2018; the Individual and Family Support Program, Licensing Rules and Regulations; REACH and the state’s Residential Treatment Facilities; the transition of children from living in Nursing Homes and ICFs; the status of the Commonwealth’s renewal and approval of its application(s) to CMS; the effectiveness of the Commonwealth’s Performance Contracts with the Community Service Boards; and an Individual Services Review study of individuals who have completed Discharge and Transition from the Training Centers.

Throughout the recent review period, the Commonwealth’s staff have been accessible, forthright and responsive. Attorneys from the Department of Justice continued to gather information that has been helpful to effective implementation of the Agreement. They continue to work collaboratively with the Commonwealth in negotiating outcomes and timelines for achieving the provisions of the Agreement. Overall, the willingness of both Parties to openly and regularly discuss implementation issues, and any concerns about progress towards shared goals, has been important and productive. The involvement and contributions of the advocates and other stakeholders continues to be vitally important to the progress that the Commonwealth has made. The Independent Reviewer greatly appreciates the assistance that was so generously given by the individuals at the center of this Agreement and their families, their Case Managers and their service providers.

## II. SUMMARY OF COMPLIANCE

Settlement Agreement Reference	Provision	Rating	Comments
<b>III</b>	<b>Serving Individuals with Developmental Disabilities in the Most Integrated Setting</b>	<p><b>Compliance ratings for the fifth, sixth, seventh, eighth and ninth review periods are presented as:</b></p> <p style="text-align: center;"><i>7<sup>th</sup> period</i> <u>8<sup>th</sup> period</u> (9<sup>th</sup> period) <b>11<sup>th</sup> period</b></p>	<p><b>Comments include examples to explain the ratings and status. The Findings Section and attached consultant reports include additional explanatory information.</b></p> <p><i>The Comments in italics below are from the prior period when the compliance rating was determined.</i></p>
<b>III.C.1.a.i-vii</b>	The Commonwealth shall create a minimum of 805 waiver slots to enable individuals in the target population in the Training Centers to transition to the community ... vii. In State Fiscal Year 2018, 90 waiver slots	<p style="text-align: center;"><i>Compliance</i> <u>Compliance</u> (Compliance)</p> <p style="text-align: center;"><b>Compliance</b></p>	The Commonwealth created 100 waiver slots during FY 2018, ten more than the minimum number required for individuals to transition from Training Centers.
<b>III.C.1.b.i-vii</b>	The Commonwealth shall create a minimum of 2,915 waiver slots to prevent the institutionalization of individuals with intellectual disabilities in the target population who are on the urgent waitlist for a waiver, or to transition to the community, individuals with intellectual disabilities under 22 years of age from institutions other than the Training Centers (i.e., ICFs and nursing facilities) ... vii. In State Fiscal Year 2018, 325 waiver slots.	<p style="text-align: center;"><i>Non Compliance</i> <u>Non Compliance</u> (Non Compliance)</p> <p style="text-align: center;"><b>Non Compliance</b></p>	The Commonwealth created 80 waiver slots in FY 2018, which does not yet meet the quantitative requirements of this provision. A few children in nursing facilities and ICFs had used the prioritized waiver slots. The substantive change, expected by the Spring of 2017 from implementing the Commonwealth's plan, has not occurred. See comment immediately below.

<b>Settlement Agreement Reference</b>	<b>Provision</b>	<b>Rating</b>	<b>Comments</b>
<b><u>III.C.1.c.i-vii</u></b>	The Commonwealth shall create a minimum of 450 waiver slots to prevent the institutionalization of individuals with developmental disabilities other than intellectual disabilities in the target population who are on the waitlist for a waiver, or to transition to the community individuals with developmental disabilities other than intellectual disabilities under 22 years of age from institutions other than the Training Centers (i.e., ICFs and nursing facilities) ... vii. In State Fiscal Year 2018, 25 waiver slots, including 10 prioritized for individuals under 22 years of age residing in nursing homes and the largest ICFs	<i>Non Compliance</i> (Non Compliance)  <b>Non Compliance</b>	The Commonwealth created 344 waiver slots in FY 2018 for individuals with DD, other than ID, 319 more than required. The Commonwealth's expected results from implementing its plan to transition children living in ICFs and nursing facilities has not occurred. For III.C.1. b. and c., only 23 of the 180 (12.8%) prioritized slots in FY 13 - FY18, have been used.
<b><u>III.C.2.a-b</u></b>	The Commonwealth shall create an Individual and Family Support Program (IFSP) for individuals with IDD whom the Commonwealth determines to be the most at risk of institutionalization. In the State Fiscal Year 2018, a minimum of 1000 individuals will be supported.	<u>Non Compliance</u> (Non Compliance)  <b>Non Compliance</b>	The Commonwealth continues to meet the quantitative requirement. DBHDS developed a plan; implementation will be evident during 2018.
<b><u>III.C.5.a</u></b>	The Commonwealth shall ensure that individuals receiving HCBS waiver services under this Agreement receive case management.	<u>Compliance</u> <u>Compliance</u>  <b>Compliance</b>	51 (100%) of the individuals reviewed in the individual services review studies during the 10 <sup>th</sup> and 11 <sup>th</sup> periods had case managers and had current Individual Support Plans.
<b><u>III.C.5.b.</u></b>	For the purpose of this agreement, case management shall mean:		
<b><u>III.C.5.b.i.</u></b>	Assembling professionals and nonprofessionals who provide individualized supports, as well as the individual being served and other persons important to the individual being served, who, through their combined expertise and involvement, develop Individual Support Plans ("ISP") that are individualized, person-centered, and meet the individual's needs.	<i>Non Compliance</i> <u>Non Compliance</u>  <b>Non Compliance</b>	The Individual Services Review and Case management studies found continuing inadequacies in case management performance. See Compliance Findings: Serving Individuals with Complex Needs" and "Case Management".



<b>Settlement Agreement Reference</b>	<b>Provision</b>	<b>Rating</b>	<b>Comments</b>
<b>III.C.5.b.ii</b>	Assisting the individual to gain access to needed medical, social, education, transportation, housing, nutritional, therapeutic, behavioral, psychiatric, nursing, personal care, respite, and other services identified in the ISP.	<i>Non Compliance</i> <u>Non Compliance</u> <b>Non Compliance</b>	See comment immediately above.
<b>III.C.5.b.iii</b>	Monitoring the ISP to make timely additional referrals, service changes, and amendments to the plans as needed.	<i>Non Compliance</i> <u>Non Compliance</u> <b>Non Compliance</b>	See comment regarding III.C.5.b.i.
<b><u>III.C.5.c</u></b>	Case management shall be provided to all individuals receiving HCBS waiver services under this Agreement by case managers who are not directly providing such services to the individual or supervising the provision of such services. The Commonwealth shall include a provision in the Community Services Board (“CSB”) Performance Contract that requires CSB case managers to give individuals a choice of service providers from which the individual may receive approved waiver services and to present practicable options of service providers based on the preferences of the individual, including both CSB and non-CSB providers.	<u>Compliance</u> (Deferred) <b>Non Compliance</b>	The Individual Services Review case study found that case managers had offered choices of residential and day providers, but whether 34 (67%) of 51 individuals were offered a choice of case managers was not documented. The Commonwealth has made this offer contingent on the individual or AR informing the current case manager of dissatisfaction with his or her services.
<b><u>III.C.5.d</u></b>	The Commonwealth shall establish a mechanism to monitor compliance with performance standards.	<i>Non Compliance</i> (Non Compliance) <b>Non Compliance</b>	The DBHDS licensing regulations and monitoring protocols do not align with the Agreement’s requirements.
<b><u>III.C.6.a.i-iii</u></b>	The Commonwealth shall develop a statewide crisis system for individuals with intellectual and developmental disabilities. The crisis system shall:  i. Provide timely and accessible support ...  ii. Provide services focused on crisis prevention and proactive planning ...  iii. Provide in-home and community-based crisis services that are directed at resolving crises and preventing the removal of the individual ...	<u>Non Compliance</u> (Non Compliance) <b>Non Compliance</b>	This is an overarching provision. Compliance will not be achieved until the Commonwealth is in compliance with the components of Crisis Services as specified in the provisions of the Agreement.

<b>Settlement Agreement Reference</b>	<b>Provision</b>	<b>Rating</b>	<b>Comments</b>
<b><u>III.C.6.b.i.A</u></b>	The Commonwealth shall utilize existing CSB Emergency Services, including existing CSB hotlines, for individuals to access information about referrals to local resources. Such hotlines shall be operated 24 hours per day, 7 days per week.	<i>Compliance</i> <u>Compliance</u> (Compliance)  <b>Compliance</b>	CSB Emergency Services are utilized. REACH hotlines are operated 24 hours per day, 7 days per week, for adults and for children with IDD.
<b><u>III.C.6.b.i.B</u></b>	By June 30, 2012, the Commonwealth shall train CSB Emergency Services (ES) personnel in each Health Planning Region on the new crisis response system it is establishing, how to make referrals, and the resources that are available.	<i>Compliance</i> <u>Compliance</u> (Compliance)  <b>Compliance</b>	REACH trained 324 CSB staff and 186 ES staff during this period. The Commonwealth requires that <u>all</u> ES staff and case managers are required to attend training.
<b><u>III.C.6.b.ii.A</u></b>	Mobile crisis team members adequately trained to address the crisis shall respond to individuals at their homes and in other community settings and offer timely assessment, services, support, and treatment to de-escalate crises without removing individuals from their current placement whenever possible.	<i>Non Compliance</i> <u>Non Compliance</u>  <b>Non Compliance</b>	The Commonwealth's training programs are in place. Training has not been sufficient to de-escalate crises "without removing individuals." There has been a significant increase in admissions to state psychiatric hospitals.
<b><u>III.C.6.b.ii.B</u></b>	Mobile crisis teams shall assist with crisis planning and identifying strategies for preventing future crises and may also provide enhanced short-term capacity within an individual's home or other community setting.	<i>Non Compliance</i> <u>Non Compliance</u>  <b>Non Compliance</b>	REACH programs did not provide effective prevention plans and strategies to prevent future crises. Assessments are completed after individuals have been transported to hospitals, which has contributed to a significant increase in admissions to state psychiatric hospitals.
<b><u>III.C.6.b.ii.C</u></b>	Mobile crisis team members adequately trained to address the crisis also shall work with law enforcement personnel to respond if an individual with IDD comes into contact with law enforcement.	<i>Compliance</i> <u>Compliance</u> (Compliance)  <b>Compliance</b>	During the review period, REACH continued to train law enforcement personnel. A total of 511 law enforcement personnel was trained by the five Regions' REACH Teams.
<b><u>III.C.6.b.ii.D</u></b>	Mobile crisis teams shall be available 24 hours per day, 7 days per week and to respond on-site to crises.	<i>Compliance</i> (Compliance)  <b>Compliance</b>	REACH Mobile crisis teams for children and adults are available around the clock and respond on-site at all hours of the day and night.

<b>Settlement Agreement Reference</b>	<b>Provision</b>	<b>Rating</b>	<b>Comments</b>
<b><u>III.C.6.b.ii.E</u></b>	Mobile crisis teams shall provide local and timely in home crisis support for up to three days, with the possibility of an additional period of up to 3 days upon review by the Regional Mobile Crisis Team Coordinator	<i>Compliance</i> <u>Compliance</u> (Compliance)  <b>Compliance</b>	Four Regions provided adults with IDD with more than an average of three days in-home supports. Region IV has provided only an average of 2.6 days of support.
<b><u>III.C.6.b.ii.H</u></b>	By June 30, 2014, the Commonwealth shall have a sufficient number of mobile crisis teams in each Region to respond to on-site to crises as follows: in urban areas within one hour, in rural areas within two hours, as measured by the average annual response time.	<i>Compliance</i> (Compliance)  <b>Compliance</b>	The Commonwealth did not create new teams. It added staff to the existing teams. REACH teams in all five Regions responded within the required average annual response times during the eleventh review period.
<b><u>III.C.6.b.iii.A.</u></b>	Crisis Stabilization programs offer a short-term alternative to institutionalization or hospitalization for individuals who need inpatient stabilization services	<i>Compliance</i> (Compliance)  <b>Compliance</b>	All Regions continue to have crisis stabilization programs that are providing short-term alternatives for adults with IDD.
<b><u>III.C.6.b.iii.B.</u></b>	Crisis stabilization programs shall be used as a last resort. The State shall ensure that, prior to transferring an individual to a crisis stabilization program, the mobile crisis team, in collaboration with the provider, has first attempted to resolve the crisis to avoid an out-of-home placement and, if that is not possible, has then attempted to locate another community-based placement that could serve as a short-term placement.	<i>Compliance</i> Compliance (Compliance)  <b>Compliance</b>	For adults with IDD admitted to the programs, crisis stabilization programs continue to be used as a last resort. For these individuals, teams attempted to resolve crises and avoid out-of-home placements.
<b><u>III.C.6.b.iii.D.</u></b>	Crisis stabilization programs shall have no more than six beds and lengths of stay shall not exceed 30 days.	Non Compliance (Non Compliance)  <b>Non Compliance</b>	Each Region's crisis stabilization programs significantly reduced its average length of stay; some stays continue to exceed 30 days, which are not allowed. Two homes that allow long term stays are being developed.

Settlement Agreement Reference	Provision	Rating	Comments
<b><u>III.C.6.b.iii.E.</u></b>	With the exception of the Pathways Program at SWVTC ... crisis stabilization programs shall not be located on the grounds of the Training Centers or hospitals with inpatient psychiatric beds. By July 1, 2015, the Pathways Program at SWVTC will cease providing crisis stabilization services and shall be replaced by off-site crisis stabilization programs with sufficient capacity to meet the needs of the target population in that Region.	<i>Substantial Compliance</i> <u>Non Compliance</u>  <b>Non Compliance</b>	The Commonwealth does not have sufficient community-based crisis stabilization service capacity to meet the needs of the target population in the Region.
<b><u>III.C.6.b.iii.F.</u></b>	By June 30, 2012, the Commonwealth shall develop one crisis stabilization program in each Region.	<i>Compliance (Compliance)</i>  <b>Compliance</b>	Each Region developed and currently maintains a crisis stabilization program for adults with IDD.
<b><u>III.C.6.b.iii.G.</u></b>	By June 30, 2013, the Commonwealth shall develop an additional crisis stabilization program in each Region as determined necessary by the Commonwealth to meet the needs of the target population in that Region.	<i>Non Compliance (Compliance)</i> <u>Non Compliance</u>  <b>Non Compliance</b>	The Commonwealth has determined that it is not necessary to develop additional “crisis stabilization programs” for adults in each Region. It has decided to add two programs statewide to meet the crisis stabilization needs of individuals who require longer stays. These programs have not been developed.
<b><u>III.C.7.a</u></b>	To the greatest extent practicable, the Commonwealth shall provide individuals in the target population receiving services under this Agreement with integrated day opportunities, including supported employment.	<i>Non Compliance (Non Compliance)</i>  <b>Non Compliance</b>	This is an overarching provision. Compliance will not be achieved until the component provisions of integrated day, including supported employment, are in compliance.

<b>Settlement Agreement Reference</b>	<b>Provision</b>	<b>Rating</b>	<b>Comments</b>
<b><u>III.C.7.b</u></b>	The Commonwealth shall maintain its membership in the State Employment Leadership Network (“SELN”) established by the National Association of State Developmental Disabilities Directors. The Commonwealth shall establish a state policy on Employment First for the target population and include a term in the CSB Performance Contract requiring application of this policy... (3) employment services and goals <u>must be developed and discussed at least annually</u> through a person-centered planning process and included in the ISP.	<i>Non Compliance</i> (Non Compliance)  <b>Non Compliance</b>	The Individual Services Review study found that employment services and goals were not developed and discussed for 15 of 40 individuals (40%). ISPs frequently include checked boxes that indicate employment was discussed, but there were no records that possible goals were developed and discussed, which would ensure a meaningful discussion.
<b><u>III.C.7.b.i.</u></b>	Within 180 days of this Agreement, the Commonwealth shall develop, as part of its Employment First Policy, an implementation plan to increase integrated day opportunities for individuals in the target population, including supported employment, community volunteer activities, community recreation opportunities, and other integrated day activities.	<i>Non Compliance</i> (Compliance)  <b>Compliance</b>	The Commonwealth had previously developed a plan for Supported Employment. It has revised and improved its implementation plan with stronger and required elements for integrated day opportunities/activities.
<b><u>III.C.7.b.i.A.</u></b>	Provide regional training on the Employment First policy and strategies through the Commonwealth.	<i>Compliance</i> (Compliance)  <b>Compliance</b>	DBHDS continued to provide regional training on the Employment First policy and strategies.
<b><u>III.C.7.b.i.</u></b> <b><u>B.1.</u></b>	Establish, for individuals receiving services <i>through the HCBS waivers</i> , annual baseline information regarding:		The Commonwealth has significantly improved its method of collecting data. For the third consecutive period, data were reported by 100% of the employment service providers. It can now report the number of individuals, length of time, and earnings as required in III.C.7.b.i.B.1.a, b, c, d, and e below.
<b><u>III.C.7.b.i.</u></b> <b><u>B.1.a.</u></b>	The number of individuals who are receiving supported employment.	<i>Non Compliance</i> (Compliance)  <b>Compliance</b>	<u>See answer for III.C.7.b.i.B.1.</u>

<b>Settlement Agreement Reference</b>	<b>Provision</b>	<b>Rating</b>	<b>Comments</b>
<b><u>III.C.7.b.i.</u></b> <b><u>B.1.b.</u></b>	The length of time individuals maintain employment in integrated work settings.	<i>Non Compliance</i> (Compliance) <b>Compliance</b>	<u>See answer for III.C.7.b.i.B.1.</u>
<b><u>III.C.7.b.i.</u></b> <b><u>B.1.c.</u></b>	Amount of earnings from supported employment;	<i>Non Compliance</i> (Compliance) <b>Compliance</b>	<u>See answer for III.C.7.b.i.B.1.</u>
<b><u>III.C.7.b.i.</u></b> <b><u>B.1.d.</u></b>	The number of individuals in pre-vocational services.	<i>Compliance</i> (Compliance) <b>Compliance</b>	<u>See answer for III.C.7.b.i.B.1.</u>
<b><u>III.C.7.b.i.</u></b> <b><u>B.1.e.</u></b>	The length-of-time individuals remain in pre-vocational services.	<i>Compliance</i> (Compliance) <b>Compliance</b>	<u>See answer for III.C.7.b.i.B.1.</u>
<b><u>III.C.7.b.i.</u></b> <b><u>B.2.a.</u></b>	Targets to meaningfully increase: the number of individuals who enroll in supported employment each year.	<i>Non Compliance</i> <b>Non Compliance</b>	The Commonwealth set targets to meaningfully increase the number of individuals receiving waiver-funded services. It did not make substantial progress toward achieving the targets. During the most recent six-month period, the number of individuals in supported employment declined. The Commonwealth has not identified or addressed the systemic obstacles to increasing employment.
<b><u>III.C.7.b.i.</u></b> <b><u>B.2.b.</u></b>	The number of individuals who remain employed in integrated work settings at least 12 months after the start of supported employment.	<i>Non Compliance</i> (Compliance) <b>Compliance</b>	The Commonwealth has improved data collection. 84% of the individuals had worked at their job for at least twelve months, one percent short of its goal of 85%.

<b>Settlement Agreement Reference</b>	<b>Provision</b>	<b>Rating</b>	<b>Comments</b>
<b>III.C.7.c.</b>	Regional Quality Councils (RQC), described in V.D.5. ... shall review data regarding the extent to which the targets identified in Section III.C.7.b.i.B.2 above are being met. These data shall be provided quarterly ... Regional Quality Councils shall consult with providers with the SELN regarding the need to take additional measures to further enhance these services.	<i>Non Compliance</i> (Compliance)  <b>Compliance</b>	The RQCs met during each quarter of the tenth and eleventh review periods. They consulted with the DBHDS Employment staff, both members of the SELN (aka EFAG). The RQCs completed required quarterly reviews.
<b>III.C.7.d.</b>	The Regional Quality Councils shall annually review the targets set pursuant to Section III.C.7.b.i.B.2 above and shall work with providers and the SELN in determining whether the targets should be adjusted upward.	<i>Non Compliance</i> (Compliance)  <b>Compliance</b>	The RQCs reviewed the employment targets and the State's progress for FY 2017. The RQCs discussed and endorsed the future FY 2016 – 2019 targets.
<b>III.C.8.a.</b>	The Commonwealth shall provide transportation to individuals receiving HCBS waiver services in the target population in accordance with the Commonwealth's HCBS Waivers.	<i>Non Compliance</i> (Non Compliance)  <b>Non Compliance</b>	A review found that DMAS /Broker have implemented previous recommendations and DMAS added them to its RFP, which it has had to reissue. Sustained improvements and a functioning quality improvement program will not be able to be evaluated until 2019.
<b><u>III.C.8.b.</u></b>	The Commonwealth shall publish guidelines for families seeking intellectual and developmental disability services on how and where to apply for and obtain services. The guidelines will be updated annually and will be provided to appropriate agencies for use in directing individuals in the target population to the correct point of entry to access services.	<i>Non Compliance</i> <u>Non Compliance</u> (Non Compliance)	<i>The Commonwealth will not revise its guidelines until after implementing its redesigned HCBS waivers.</i>
<b><u>III.D.1.</u></b>	The Commonwealth shall serve individuals in the target population in the most integrated setting consistent with their informed choice and needs.	<u>Non Compliance</u> (Non Compliance)  <b>Non Compliance</b>	This is an overarching provision. The need for more integrated settings will not be resolved until full implementation of the redesigned waivers and additional provider development, especially to serve individuals with intense needs.

<b>Settlement Agreement Reference</b>	<b>Provision</b>	<b>Rating</b>	<b>Comments</b>
<b><u>III.D.2.</u></b>	The Commonwealth shall facilitate individuals receiving HCBS waivers under this Agreement to live in their own home, leased apartment, or family's home, when such a placement is their informed choice and the most integrated setting appropriate to their needs. To facilitate individuals living independently in their own home or apartment, the Commonwealth shall provide information about and make appropriate referrals for individuals to apply for rental or housing assistance and bridge funding through all existing sources.	<u>Non Compliance</u> <b>Compliance</b>	The Commonwealth has created 553 independent housing options and is almost a year ahead of its goal to achieve 847 new options by FY2021.
<b><u>III.D.3.</u></b>	Within 365 days of this Agreement, the Commonwealth shall develop a plan to increase access to independent living options such as individuals' own homes or apartments.	<u>Compliance</u> (Compliance) <b>Compliance</b>	The Commonwealth developed a plan, created strategies to improve access, and provided rental subsidies.
<b><u>III.D.3.a.</u></b>	The plan will be developed under the direct supervision of a dedicated housing service coordinator for the Department of Behavioral Health and Developmental Services ("DBHDS") and in coordination with representatives from the Department of Medical Assistance Services ("DMAS"), Virginia Board for People with Disabilities, Virginia Housing Development Authority, Virginia Department of Housing and Community Development, and other organizations ...	<u>Compliance</u> (Compliance) <b>Compliance</b>	A DBHDS housing service coordinator developed and updated the plan with these representatives and with others.
<b><u>III.D.3.b.i-ii</u></b>	The plan will establish for individuals receiving or eligible to receive services through the HCBS waivers under this Agreement: Baseline information regarding the number of individuals who would choose the independent living options described above, if available; and Recommendations to provide access to these settings during each year of this Agreement.	<u>Compliance</u> <u>Compliance</u> (Compliance) <b>Compliance</b>	The Commonwealth estimated the number of individuals who would choose independent living options through FY 2015. It again revised its Housing Plan with new strategies and recommendations.
<b><u>III.D.4</u></b>	Within 365 days of this Agreement, the Commonwealth shall establish and begin distributing from a one-time fund of \$800,000 to provide and administer rental assistance in accordance with the recommendations described above in Section III.D.3.b.ii.	Compliance (Compliance) <b>Compliance and Completed</b>	The Commonwealth established the one-time fund, distributed funds, and demonstrated viability of providing rental assistance. The individuals who received these one-time



<b>Settlement Agreement Reference</b>	<b>Provision</b>	<b>Rating</b>	<b>Comments</b>
			funds have been provided permanent rental assistance.
<b><u>III.D.5</u></b>	Individuals in the target population shall not be served in a sponsored home or any congregate setting, unless such placement is consistent with the individual's choice after receiving options for community placements, services, and supports consistent with the terms of Section IV.B.9 below.	<i>Non Compliance</i> <u>Non Compliance</u> <b>Non Compliance</b>	Family-to-family and peer programs were not active for individuals who live in the community and their families.
<b><u>III.D.6</u></b>	No individual in the target population shall be placed in a nursing facility or congregate setting with five or more individuals unless such placement is consistent with the individual's needs and informed choice and has been reviewed by the Region's Community Resource Consultant (CRC) and, under circumstances described in Section III.E below, the Regional Support Team (RST).	<i>Non Compliance</i> <u>Non Compliance</u> <b>Non Compliance</b>	Children and adults were placed in settings of five or more, including nursing facilities and ICFs, without the prior review of the CRC or the Regional Support Teams.
<b><u>III.D.7</u></b>	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 ...	<i>Compliance</i> <u>Compliance</u> (Compliance) <b>Compliance</b>	The Commonwealth included this term in its performance contracts with CSBs. This offer is outlined in the ISP which is acknowledged, approved and signed by the individual/Authorized Representative.
<b><u>III.E.1</u></b>	The Commonwealth shall utilize Community Resource Consultant ("CRC") positions located in each Region to provide oversight and guidance to CSBs and community providers, and serve as a liaison between the CSB case managers and DBHDS Central Office... The CRCs shall be a member of the Regional Support Team ...	<i>Compliance</i> <u>Compliance</u> (Compliance) <b>Compliance</b>	Community Resource Consultants (CRCs) are located in each Region, are members of the Regional Support Teams, and are utilized for these functions.

Settlement Agreement Reference	Provision	Rating	Comments
III.E.2	The CRC may consult at any time with the Regional Support Team (RST). Upon referral to it, the RST shall work with the Personal Support Team (“PST”) and CRC to review the case, resolve identified barriers, and ensure that the placement is the most integrated setting appropriate to the individual’s needs, consistent with the individual’s informed choice. The RST shall have the authority to recommend additional steps by the PST and/or CRC.	<p><i>Non Compliance</i>  <u>Non Compliance</u></p> <p><b>Non Compliance</b></p>	Case Managers frequently did not submit referrals, as required, to allow the CRCs and the RSTs to review cases prior to the placement. DBHDS reports that 18%-48% of referrals were late during the four quarters of 2017. Late referrals largely nullify the purpose of the RST review.
III.E.3.a-d	The CRC shall refer cases to the Regional Support Teams (RST) for review, assistance in resolving barriers, or recommendations whenever (specific criteria are met).	<p><u>Compliance</u>                      (Compliance)</p> <p><b>Compliance</b></p>	DBHDS established the RSTs, which meet monthly. The CRCs refer cases to the RSTs regularly.
IV	<b>Discharge Planning and Transition</b>	<p><b>Compliance ratings for the seventh, eighth ninth and eleventh review periods are presented as:</b></p> <p><i>7<sup>th</sup> period</i>  <i>8<sup>th</sup> period</i>  <i>(9<sup>th</sup> period)</i>  <b>11<sup>th</sup> period</b></p>	<p><b>Note: The Independent Reviewer gathered information about individuals who transitioned from Training Centers and rated compliance during the fifth, seventh and ninth review periods.</b></p> <p><b><i>The Comments in italics below are from the period when the compliance rating was determined.</i></b></p>
IV.	By July 2012, the Commonwealth will have implemented Discharge and Transition Planning processes at all Training Centers consistent with the terms of this section	<p><i>Compliance</i>                      (Compliance)</p> <p><b>Compliance</b></p>	The Commonwealth developed and implemented discharge planning and transition processes prior to July 2012. It implemented improvements in response to concerns the IR identified.
IV.A	To ensure that individuals are served in the most integrated setting appropriate to their needs, the Commonwealth shall develop and implement discharge planning and transition processes at all Training Centers consistent with the terms of this Section and person-centered principles.	<p><i>Non Compliance</i>                      (Non Compliance)</p>	<i>The Commonwealth had just begun to implement the redesigned HCBS waivers to come into compliance. Most integrated residential and day options are not available for individuals with intense needs.</i>

<b>Settlement Agreement Reference</b>	<b>Provision</b>	<b>Rating</b>	<b>Comments</b>
<b>IV.B.3.</b>	Individuals in Training Centers shall participate in their treatment and discharge planning to the maximum extent practicable, regardless of whether they have authorized representatives. Individuals shall be provided the necessary support (including, but not limited to, communication supports) to ensure that they have a meaningful role in the process.	<i>Compliance</i> (Compliance)	<i>The Independent Reviewer's Individual Services Review studies found that DBHDS has consistently complied with this provision. The discharge plans reviewed were well organized and well documented.</i>
<b>IV.B.4.</b>	The goal of treatment and discharge planning shall be to assist the individual in achieving outcomes that promote the individual's growth, wellbeing, and independence, based on the individual's strengths, needs, goals, and preferences, in the most integrated settings in all domains of the individual's life (including community living, activities, employment, education, recreation, healthcare, and relationships).	<i>Non Compliance</i> (Non Compliance)	<i>Discharge plan goals did not include measurable outcomes that promote integrated day activities for most individuals. The Commonwealth had just begun to provide integrated day services and some progress was apparent.</i>
<b>IV.B.5.</b>	The Commonwealth shall ensure that discharge plans are developed for all individuals in its Training Centers through a documented person-centered planning and implementation process and consistent with the terms of this Section. The discharge plan shall be an individualized support plan for transition into the most integrated setting consistent with informed individual choice and needs and shall be implemented accordingly. The final discharge plan will be developed within 30 days prior to discharge.	<i>Compliance</i> (Compliance)	<i>The Independent Reviewer's Individual Services Review studies found that DBHDS has consistently complied with this provision. The discharge plans are well documented. All individuals studied had discharge plans.</i>
<b>IV.B.5.a.</b>	Provision of reliable information to the individual and, where applicable, the authorized representative, regarding community options in accordance with Section IV.B.9;	<i>Compliance</i> (Compliance)	<i>The documentation of information provided was present in the discharge records</i> • <i>for 26 (100%) of the individuals studied during the ninth review period.</i>
<b>IV.B.5.b.</b>	Identification of the individual's strengths, preferences, needs (clinical and support), and desired outcomes;	<i>Compliance</i> (Compliance)	<i>The discharge plans included this information.</i>
<b>IV.B.5.c.</b>	Assessment of the specific supports and services that build on the individual's strengths and preferences to meet the individual's needs and achieve desired outcomes, regardless of whether those services and supports are currently available;	<i>Compliance</i> (Compliance)	• <i>for 76 of 77 individuals (98.7%) studied during the fifth, seventh, and ninth review periods, the discharge records included these assessments.</i>

<b>Settlement Agreement Reference</b>	<b>Provision</b>	<b>Rating</b>	<b>Comments</b>
<b>IV.B.5.d.</b>	Listing of specific providers that can provide the identified supports and services that build on the individual's strengths and preferences to meet the individual's needs and achieve desired outcomes;	<i>Compliance</i> (Compliance)	<i>The PSTs select and list specific providers that provide identified supports and services.</i>
<b>IV.B.5.e.</b>	Documentation of barriers preventing the individual from transitioning to a more integrated setting and a plan for addressing those barriers.	<i>Compliance</i> (Compliance) <b>Compliance</b>	The Training Centers document barriers in six broad categories as well as more specific barriers.
<b>IV.B.5.e.i.</b>	Such barriers shall not include the individual's disability or the severity of the disability.	<i>Compliance</i> (Compliance) <b>Compliance</b>	The severity of the disability has not been a barrier in the discharge plans.
<b>IV.B.5.e.ii.</b>	For individuals with a history of re-admission or crises, the factors that led to re-admission or crises shall be identified and addressed.	<i>Compliance</i> (Compliance)	<i>DBHDS has identified the factors that led to readmission and has implemented steps to support individuals with intensive needs.</i>
<b>IV.B.6</b>	Discharge planning will be done by the individual's PST... Through a person-centered planning process, the PST will assess an individual's treatment, training, and habilitation needs and make recommendations for services, including recommendations of how the individual can be best served.	<i>Non Compliance</i> (Non Compliance)	<i>The Individual Services Review Study found that the discharge plans lacked recommendations for services in integrated day opportunities. DBHDS implemented improvements that led to more plans that included skill development goals.</i>
<b>IV.B.7</b>	Discharge planning shall be based on the presumption that, with sufficient supports and services, all individuals (including individuals with complex behavioral and/or medical needs) can live in an integrated setting.	<i>Compliance</i> (Compliance) <b>Compliance</b>	The Commonwealth's discharge plans indicate that individuals with complex needs can live in integrated settings.
<b>IV.B.9.</b>	In developing discharge plans, PSTs, in collaboration with the CSB case manager, shall provide to individuals and, where applicable, their authorized representatives, specific options for types of community placements, services, and supports based on the discharge plan as described above, and the opportunity to discuss and meaningfully consider these options.	<i>Compliance</i> (Compliance)	<i>The Individual Services Review studies during the fifth seventh, and ninth review periods found that 78 (100%) of individuals and their ARs were provided with information regarding community options and had the opportunity to discuss them with the PST.</i>
<b>IV.B.9.a.</b>	The individual shall be offered a choice of providers consistent with the individual's identified needs and preferences.	<i>Compliance</i> (Compliance)	<i>Discharge records included evidence that the Commonwealth had offered a choice of providers.</i>

<b>Settlement Agreement Reference</b>	<b>Provision</b>	<b>Rating</b>	<b>Comments</b>
<b>IV.B.9.b.</b>	PSTs and the CSB case manager shall coordinate with the ... community providers identified in the discharge plan as providing appropriate community-based services for the individual, to provide individuals, their families, and, where applicable, their authorized representatives with opportunities to speak with those providers, visit community placements (including, where feasible, for overnight visits) and programs, and facilitate conversations and meetings with individuals currently living in the community and their families, before being asked to make a choice regarding options. The Commonwealth shall develop family-to-family peer programs to facilitate these opportunities.	<i>Non Compliance</i> (Compliance)	<i>Reviews found that</i> <ul style="list-style-type: none"> <li>• 22 of 26 individuals (84.5%) and their ARs did have an opportunity to speak with individuals currently living in their communities and their family members. All 100% received a packet of information with this offer, but discussions and follow-up were not documented for four individuals.</li> </ul>
<b>IV.B.9.c.</b>	PSTs and the CSB case managers shall assist the individual and, where applicable, their authorized representative in choosing a provider after providing the opportunities described above and ensure that providers are timely identified and engaged in preparing for the individual's transition.	<i>Compliance</i> (Compliance)	<i>PST's and case managers assisted individuals and their Authorized Representative. For 100% of the 26 individuals studied, providers were identified and engaged; provider staff were trained in support plan protocols.</i>
<b>IV.B.11.</b>	The Commonwealth shall ensure that Training Center PSTs have sufficient knowledge about community services and supports to: propose appropriate options about how an individual's needs could be met in a more integrated setting; present individuals and their families with specific options for community placements, services, and supports; and, together with providers, answer individuals' and families' questions about community living.	<i>Compliance</i> (Compliance)	<i>During the fifth, seventh, and ninth review periods, the reviews found that</i> <ul style="list-style-type: none"> <li>• 70 of 78 individuals /Authorized Representatives (89.7%) who transitioned from Training Centers were provided with information regarding community options.</li> </ul>
<b>IV.B.11.a.</b>	In collaboration with the CSB and Community providers, the Commonwealth shall develop and provide training and information for Training Center staff about the provisions of the Agreement, staff obligations under the Agreement, current community living options, the principles of person-centered planning, and any related departmental instructions. The training will be provided to all applicable disciplines and all PSTs.	<i>Compliance</i> (Compliance)	<i>The Independent Reviewer confirmed that training has been provided via regular orientation, monthly and ad hoc events at all Training Centers, and via ongoing information sharing.</i>

<b>Settlement Agreement Reference</b>	<b>Provision</b>	<b>Rating</b>	<b>Comments</b>
<b><u>IV.B.11.b.</u></b>	Person-centered training will occur during initial orientation and through annual refresher courses. Competency will be determined through documented observation of PST meetings and through the use of person-centered thinking coaches and mentors. Each Training Center will have designated coaches who receive additional training. The coaches will provide guidance to PSTs to ensure implementation of the person-centered tools and skills. Coaches ... will have regular and structured sessions and person-centered thinking mentors. These sessions will be designed to foster additional skill development and ensure implementation of person centered thinking practices throughout all levels of the Training Centers.	<i>Compliance</i> (Compliance)	<i>The Independent Reviewer confirmed that staff receive required person-centered training during orientation and annual refresher training. All Training Centers have person-centered coaches. DBHDS reports that regularly scheduled conferences provide opportunities to meet with mentors. An extensive list of trainings was provided and attendance is well documented.</i>
<b>IV.B.14</b>	In the event that a PST makes a recommendation to maintain placement at a Training Center or to place an individual in a nursing home or congregate setting with five or more individuals, the decision shall be documented, and the PST shall identify the barriers to placement in a more integrated setting and describe in the discharge plan the steps the team will take to address the barriers. The case shall be referred to the Community Integration Manager and Regional Support Team in accordance with Sections IV.D.2.a and f and IV.D.3 and such placements shall only occur as permitted by Section IV.C.6.	<i>Non Compliance</i>	<i>See Comment for IV.D.3.</i>
<b>IV.C.1</b>	Once a specific provider is selected by an individual, the Commonwealth shall invite and encourage the provider to actively participate in the transition of the individual from the Training Center to the community placement.	<i>Compliance</i> (Compliance)	<i>The Independent Reviewer found that the residential staff for</i> <ul style="list-style-type: none"> <li>• 100% of the 26 individuals participated in the pre-move ISP meeting and were trained in the support plan protocols.</li> </ul>
<b>IV.C.2</b>	Once trial visits are completed, the individual has selected a provider, and the provider agrees to serve the individual, discharge will occur within 6 weeks, absent conditions beyond the Commonwealth's control. If discharge does not occur within 6 weeks, the reasons it did not occur will be documented and a new time frame for discharge will be developed by the PST.	<i>Compliance</i> (Compliance)	<i>During the fifth, seventh, and ninth period, the Independent Reviewer found that</i> <ul style="list-style-type: none"> <li>• 75 of 78 individuals (96.2%) had moved within 6 weeks, or reasons were documented and new time frames developed.</li> </ul>

Settlement Agreement Reference	Provision	Rating	Comments
<b>IV.C.3</b>	The Commonwealth shall develop and implement a system to follow up with individuals after discharge from the Training Centers to identify gaps in care and address proactively any such gaps to reduce the risk of re-admission, crises, or other negative outcomes. The Post Move Monitor, in coordination with the CSB, will conduct post-move monitoring visits within each of three (3) intervals (30, 60, and 90 days) following an individual's movement to the community setting. Documentation of the monitoring visit will be made using the Post Move Monitoring (PMM) Checklist. The Commonwealth shall ensure those conducting Post Move Monitoring are adequately trained and a reasonable sample of look-behind Post Move Monitoring is completed to validate the reliability of the Post Move Monitoring process.	<i>Compliance</i> (Compliance)	<i>The Independent Reviewer determined the Commonwealth's PMM process is well organized. It functions with increased frequency during the first weeks after transitions.</i> • for 76 (100%) individuals PMM visits occurred. The monitors had been trained and utilized monitoring checklists. The look-behind process was maintained during the seventh period.
<b>IV.C.4</b>	The Commonwealth shall ensure that each individual transitioning from a Training Center shall have a current discharge plan, updated within 30 days prior to the individual's discharge.	<i>Compliance</i> (Compliance)	<i>The Individual Services Review studies during the ninth review period found that</i> • for 25 of 26 individuals (96.2%), the Commonwealth updated discharge plans within 30 days prior to discharge.
<b>IV.C.5</b>	The Commonwealth shall ensure that the PST will identify all needed supports, protections, and services to ensure successful transition in the new living environment, including what is most important to the individual as it relates to community placement. The Commonwealth, in consultation with the PST, will determine the essential supports needed for successful and optimal community placement. The Commonwealth shall ensure that essential supports are in place at the individual's community placement prior to the individual's discharge.	<i>Non Compliance</i> (Non Compliance)	<i>The Individual Review study found that essential supports were not in place prior to discharge for 5 of 26 individuals (19.2%) in the ninth review period. Four individuals did not have a day program and one individual did not have behavior supports in place before they moved.</i>

<b>Settlement Agreement Reference</b>	<b>Provision</b>	<b>Rating</b>	<b>Comments</b>
<b>IV.C.6</b>	No individual shall be transferred from a Training Center to a nursing home or congregate setting with five or more individuals unless placement in such a facility is in accordance with the individual's informed choice after receiving options for community placements, services, and supports and is reviewed by the Community Integration Manager to ensure such placement is consistent with the individual's informed choice.	<i>Compliance</i> (Compliance)	<i>The discharge records reviewed in the ninth review period indicated that individuals who moved to settings of five or more did so based on their informed choice after receiving options.</i>
<b>IV.C.7</b>	The Commonwealth shall develop and implement quality assurance processes to ensure that discharge plans are developed and implemented, in a documented manner, consistent with the terms of this Agreement. These quality assurance processes shall be sufficient to show whether the objectives of this Agreement are being achieved. Whenever problems are identified, the Commonwealth shall develop and implement plans to remedy the problems.	<i>Compliance</i> (Compliance)	<i>The Independent Reviewer confirmed that documented Quality Assurance processes have been implemented consistent with the terms of the Agreement. When problems have been identified, corrective actions have occurred with the discharge plans.</i>
<b>IV.D.1</b>	The Commonwealth will create Community Integration Manager ("CIM") positions at each operating Training Center.	<i>Compliance</i> (Compliance)	<i>Community Integration Managers are working at each Training Center.</i>
<b>IV.D.2.a</b>	CIMs shall be engaged in addressing barriers to discharge, including in all of the following circumstances: The PST recommends that an individual be transferred from a Training Center to a nursing home or congregate setting with five or more individuals.	<i>Compliance</i> (Compliance)	<i>CIMs reviewed PST recommendations for individuals to be transferred to a nursing home or congregate settings of five or more individuals.</i>
<b>IV.D.3</b>	The Commonwealth will create five Regional Support Teams, each coordinated by the CIM. The Regional Support Teams shall be composed of professionals with expertise in serving individuals with developmental disabilities in the community, including individuals with complex behavioral and medical needs. Upon referral to it, the Regional Support Team shall work with the PST and CIM to review the case and resolve identified barriers. The Regional Support Team shall have the authority to recommend additional steps by the PST and/or CIM.	<i>Non Compliance</i>	<i>The Commonwealth has created five Regional Support Teams. All RSTs are operating and receiving referrals. The Independent Reviewer found, during the seventh period, that</i> <ul style="list-style-type: none"> <li>• <i>for 0 (0.0%) of 12 individuals referred to the RST, there was sufficient time to work with the PST and CIM to resolve identified barriers.</i></li> </ul>



Settlement Agreement Reference	Provision	Rating	Comments
IV.D.4.	The CIM shall provide monthly reports to DBHDS Central Office regarding the types of placements to which individuals have been placed.	<i>Compliance</i> (Compliance) <b>Compliance</b>	The CIMs provide monthly reports and the Commonwealth provides the aggregated information to the Reviewer and DOJ.
V.	<b>Quality and Risk Management</b>	<b>Rating</b> <b>Compliance ratings for the seventh, eighth ninth and eleventh review periods are presented as:</b> <i>7<sup>th</sup> period</i> <i>8<sup>th</sup> period</i> <i>(9<sup>th</sup> period)</i> <b>11<sup>th</sup> period</b>	<b>Comments</b>  <i>The Comments in italics below are from the prior period when the compliance rating was determined.</i>
V.B.	The Commonwealth's Quality Management System shall: identify and address risks of harm; ensure the sufficiency, accessibility, and quality of services to meet individuals' needs in integrated settings; and collect and evaluate data to identify and respond to trends to ensure continuous quality improvement.	<i>Non Compliance</i> (Non Compliance) <b>Non Compliance</b>	This is an overarching provision of the Agreement. Compliance will not be achieved until the component sub-provisions in the Quality section are determined to be in compliance.
V.C.1	The Commonwealth shall require that all Training Centers, CSBs, and other community providers of residential and day services implement risk management processes, including establishment of uniform risk triggers and thresholds, that enable them to adequately address harms and risks of harm.	<i>Non Compliance</i> (Non Compliance) <b>Non Compliance</b>	The Commonwealth is charting a new course. It will work with the CSBs and providers to build a risk management system of triggers and thresholds at all levels of the service system.
V.C.2	The Commonwealth shall have and implement a real time, web-based incident reporting system and reporting protocol.	<i>Non Compliance</i> <u>Compliance</u> <b>Compliance</b>	DBHDS implemented a web-based incident reporting system. Providers now report 87% of incidents within one day of the event. Some late reports are duplicates of reports submitted timely.

<b>Settlement Agreement Reference</b>	<b>Provision</b>	<b>Rating</b>	<b>Comments</b>
<b>V.C.3</b>	The Commonwealth shall have and implement a process to investigate reports of suspected or alleged abuse, neglect, critical incidents, or deaths and identify remediation steps taken.	<i>Non Compliance</i> <u>Non Compliance</u> <b>Non Compliance</b>	The DBHDS Licensing investigations do not align with the requirements of the Agreement. Investigation oversight and follow-up has improved.
<b>V.C.4</b>	The Commonwealth shall offer guidance and training to providers on proactively identifying and addressing risks of harm, conducting root cause analysis, and developing and monitoring corrective actions.	<i>Non Compliance</i> (Non Compliance) <b>Non Compliance</b>	The Commonwealth is charting a new course on how it will identify individuals at risk. It is moving away from identifying triggers and thresholds based on harm that has occurred to a more proactive approach.
<b>V.C.5</b>	The Commonwealth shall conduct monthly mortality reviews for unexplained or unexpected deaths reported through its incident reporting system. The ...mortality review team ... shall have at least one member with the clinical experience to conduct mortality re who is otherwise independent of the State. Within ninety days of a death, the mortality review team shall: (a) review, or document the unavailability of: (i) medical records, including physician case notes and nurse’s notes, and all incident reports, for the three months preceding the individual’s death; ... (b) interview, as warranted, any persons having information regarding the individual’s care; and (c) prepare and deliver to the DBHDS Commissioner a report of deliberations, findings, and recommendations, if any. The team also shall collect and analyze mortality data to identify trends, patterns, and problems ... and implement quality improvement initiatives to reduce mortality rates to the fullest extent practicable.	<i>Non Compliance</i> (Non Compliance) <b>Non Compliance</b>	A Mortality Review Committee (MRC) has significantly improved its data collection, data analysis, and the quality of mortality reviews. It has begun a quality improvement program. The MRC rarely completed such reviews within 90 days; and it did not include a member, who was independent of the State.

<b>Settlement Agreement Reference</b>	<b>Provision</b>	<b>Rating</b>	<b>Comments</b>
<b>V.C.6</b>	If the Training Center, CSBs, or other community provider fails to report harms and implement corrective actions, the Commonwealth shall take appropriate action with the provider.	<i>Non Compliance</i> <b>Non Compliance</b>	DBHDS cannot effectively use available mechanisms to sanction providers, beyond use of Corrective Action Plans. DBHDS is making progress by increasingly taking “appropriate action” with agencies which fail to report timely.
<b>V.D.1</b>	The Commonwealth’s HCBS waivers shall operate in accordance with the Commonwealth’s CMS-approved waiver quality improvement plan to ensure the needs of individuals enrolled in a waiver are met, that individuals have choice in all aspects of their selection of goals and supports, and that there are effective processes in place to monitor participant health and safety. The plan shall include evaluation of level of care; development and monitoring of individual service plans; assurance of qualified providers. Review of data shall occur at the local and State levels by the CSBs and DMAS/DBHDS, respectively.	<i>Non Compliance</i> ( <i>Non Compliance</i> ) <b>Non Compliance</b>	This is an overarching provision that requires effective quality improvement processes to be in place at the CSB and state level, including monitoring of participant health and safety.
<b>V.D.2.a-d</b>	The Commonwealth shall collect and analyze consistent, reliable data to improve the availability and accessibility of services for individuals in the target population and the quality of services offered to individuals receiving services under this Agreement.	<i>Non Compliance</i> ( <i>Non Compliance</i> ) <b>Non Compliance</b>	DBHDS continues to expand and improve its ability to collect and analyze consistent, reliable data. These are first steps. Data elements must be defined so they can be objectively measured.
<b>V.D.3.a-h</b>	The Commonwealth shall begin collecting and analyzing reliable data about individuals receiving services under this Agreement selected from the following areas in State Fiscal Year 2012 and will ensure reliable data are collected and analyzed from each of these areas by June 30, 2014. Multiple types of sources (e.g., providers, case managers, licensing, risk management, Quality Service Reviews) can provide data in each area, though any individual type of source need not provide data in every area (as specified):	<i>Non Compliance</i> ( <i>Non Compliance</i> ) <b>Non Compliance</b>	DBHDS defined relevant measures for each domain. Staff report that efforts to produce reports based on the indicators in the eight domains are in their infancy.

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

<b>Settlement Agreement Reference</b>	<b>Provision</b>	<b>Rating</b>	<b>Comments</b>
<b>V.E.2</b>	Within 12 months of the effective date of this Agreement, the Commonwealth shall develop measures that CSBs and other community providers are required to report to DBHDS on a regular basis, either through their risk management/critical incident reporting requirements or through their QI program.	<i>Non Compliance</i> (Non Compliance)  <b>Non Compliance</b>	The Commonwealth requires providers to report deaths, serious injuries and allegations of abuse and neglect. DBHDS does not yet require reporting through the risk management and provider QI programs.
<b>V.E.3</b>	The Commonwealth shall use Quality Service Reviews and other mechanisms to assess the adequacy of providers' quality improvement strategies and shall provide technical assistance and other oversight to providers whose quality improvement strategies the Commonwealth determines to be inadequate.	<i>Non Compliance</i> (Non Compliance)  <b>Non Compliance</b>	The Commonwealth's contractor completed the second annual QSR process. There are problems with the validity of the contractor's tools and process and, therefore, with the reliability of data collected and the accuracy of the results.
<b><u>V.F.1</u></b>	For individuals receiving case management services pursuant to this Agreement, the individual's case manager shall meet with the individual face-to-face on a regular basis and shall conduct regular visits to the individual's residence, as dictated by the individual's needs.	<i>Compliance</i> <u>Compliance</u>  <b>Compliance</b>	The case management study found that 24 (96%) of the 25 case managers were in compliance with the required frequency of visits. DBHDS has reported data that frequency and type of case manager visit for some CSBs are below target
<b><u>V.F.2</u></b>	At these face-to-face meetings, the case manager shall: observe the individual and the individual's environment to assess for previously unidentified risks, injuries, needs, or other changes in status; assess the status of previously identified risks, injuries, needs, or other change in status; assess whether the individual's support plan is being implemented appropriately and remains appropriate for the individual; and ascertain whether supports and services are being implemented consistent with the individual's strengths and preferences and in the most integrated setting appropriate to the individual's needs....	<i>Non Compliance</i> <u>Non Compliance</u>  <b>Non Compliance</b>	The study of case management confirmed a high percent of discrepancies between the services individuals are receiving and those described in his/her ISP. All essential supports were not listed in the ISP. The behavioral supports study found that inadequacies in implementation of BSPs had not been identified, or corrective actions steps had not been taken.

<b>Settlement Agreement Reference</b>	<b>Provision</b>	<b>Rating</b>	<b>Comments</b>
<b><u>V.F.3.a-f</u></b>	Within 12 months of the effective date of this Agreement, the individual's case manager shall meet with the individual face-to-face at least every 30 days, and at least one such visit every two months must be in the individual's place of residence, for any individuals (who meet specific criteria).	<u>Compliance</u> (Compliance)  <b>Compliance</b>	The Individual Services Review study found that 20 of the 21 individuals' case managers (95.2%) were in compliance with the required frequency of visits. All individuals studied had received monthly face-to-face meetings as required.
<b><u>V.F.4</u></b>	Within 12 months from the effective date of this Agreement, the Commonwealth shall establish a mechanism to collect reliable data from the case managers on the number, type, and frequency of case manager contacts with the individual.	<i>Non Compliance</i> <u>Non Compliance</u>  <b>Non Compliance</b>	DBHDS does not yet have evidence at the policy level that it has reliable mechanisms to assess CSB compliance with their performance standards relative to case manager contacts.
<b><u>V.F.5</u></b>	Within 24 months from the date of this Agreement, key indicators from the case manager's face-to-face visits with the individual, and the case manager's observation and assessments, shall be reported to the Commonwealth for its review and assessment of data. Reported key indicators shall capture information regarding both positive and negative outcomes for both health and safety and community integration and will be selected from the relevant domains listed in V.D.3.	<i>Non Compliance</i> <u>Non Compliance</u>  <b>Non Compliance</b>	DBHDS does not yet have evidence at the policy level that it has reliable mechanisms to capture case manager/support coordinator findings regarding the individuals they serve.
<b><u>V.F.6</u></b>	The Commonwealth shall develop a statewide core competency-based training curriculum for case managers within 12 months of the effective date of this Agreement. This training shall be built on the principles of self-determination and person-centeredness.	<u>Compliance</u>  <b>Compliance</b>	The Commonwealth developed the curriculum with training modules that include the principles of self-determination. The modules are being updated.
<b><u>V.G.1</u></b>	The Commonwealth shall conduct regular, unannounced licensing inspections of community providers serving individuals receiving services under this Agreement.	<i>Compliance</i> <u>Compliance</u>  <b>Compliance</b>	OLS regularly conducts unannounced inspection of community providers.
<b><u>V.G.2.a-f</u></b>	Within 12 months of the effective date of this Agreement, the Commonwealth shall have and implement a process to conduct more frequent licensure inspections of community providers serving individuals ...	<i>Compliance</i> <u>Compliance</u>  <b>Compliance</b>	OLS has maintained a licensing inspection process with more frequent inspections.

<b>Settlement Agreement Reference</b>	<b>Provision</b>	<b>Rating</b>	<b>Comments</b>
<b><u>V.G.3</u></b>	Within 12 months of the effective date of this Agreement, the Commonwealth shall ensure that the licensure process assesses the adequacy of the individualized supports and services provided to persons receiving services under this Agreement in each of the domains listed in Section V.D.3 above and that these data and assessments are reported to DBHDS.	<u>Non Compliance</u> (Non Compliance)  <b>Non Compliance</b>	The DBHDS Licensing regulations and protocols do not align with the Agreement's specific requirements.
<b>V.H.1</b>	The Commonwealth shall have a statewide core competency-based training curriculum for all staff who provide services under this Agreement. The training shall include person-centered practices, community integration and self-determination awareness, and required elements of service training.	<i>Non Compliance</i> <u>Non Compliance</u>  <b>Non Compliance</b>	The Commonwealth has created a plan and has made progress developing and disseminating competencies. Some training requirements and identified competencies cannot be consistently measured and, therefore, cannot be effectively implemented, monitored, or result in reliable reporting.
<b>V.H.2</b>	The Commonwealth shall ensure that the statewide training program includes adequate coaching and supervision of staff trainees. Coaches and supervisors must have demonstrated competency in providing the service they are coaching and supervising.	<i>Non Compliance</i> <u>Non Compliance</u>  <b>Non Compliance</b>	Same as V.H.1 immediately above.
<b>V.I.1.a-b</b>	The Commonwealth shall use Quality Service Reviews ("QSRs") to evaluate the quality of services at an individual, provider, and system-wide level and the extent to which services are provided in the most integrated setting appropriate to individuals' needs and choice.	<i>Non Compliance</i> (Non Compliance)  <b>Non Compliance</b>	Same as Comments for V.E.3. Compliance will be achieved when results are based on valid and reliable data and are used to improve quality.
<b>V.I.2</b>	QSRs shall evaluate whether individuals' needs are being identified and met through person-centered planning and thinking (including building on individuals' strengths, preferences, and goals), whether services are being provided in the most integrated setting	<i>Non Compliance</i> (Non Compliance)  <b>Non Compliance</b>	Same as Comments for V.E.3 and for V.I.1. which is immediately above.
<b>V.I.3</b>	The Commonwealth shall ensure those conducting QSRs are adequately trained and a reasonable sample of look-behind QSRs are completed to validate the reliability of the QSR process.	<i>Non Compliance</i> (Non Compliance)  <b>Non Compliance</b>	Same as Comments for V.E.3 and for V.I.1.

<b>Settlement Agreement Reference</b>	<b>Provision</b>	<b>Rating</b>	<b>Comments</b>
<b>V.I.4</b>	The Commonwealth shall conduct QSRs annually of a statistically significant sample of individuals receiving services under this Agreement.	<i>Non Compliance</i> <b>Compliance</b>	The Commonwealth's contractor completed the second annual QSR process based on a statistically significant sample of individuals.
<b>VI</b>	<b>Independent Reviewer</b>	<b>Rating</b>	<b>Comment</b>
<b>VI.D.</b>	Upon receipt of notification, the Commonwealth shall immediately report to the Independent Reviewer the death or serious injury resulting in ongoing medical care of any former resident of a Training Center. The Independent Reviewer shall forthwith review any such death or injury and report his findings to the Court in a special report, to be filed under seal with the, ... shared with Intervenor's counsel.	Compliance (Compliance) <b>Compliance</b>	The DHBDS promptly reports to the IR. The IR, in collaboration with a nurse and independent consultants, completes his review and issues his Report to the Court and the Parties. DBHDS has established an internal working group to review and follow-up on the IR's recommendations.
<b>IX</b>	<b>Implementation of the Agreement</b>	<b>Rating</b>	<b>Comment</b>
<b>IX.C.</b>	The Commonwealth shall maintain sufficient records to document that the requirements of this Agreement are being properly implemented ...	Non Compliance (Non Compliance) <b>Non Compliance</b>	The Independent Reviewer has determined that the Commonwealth did not maintain sufficient records to document proper implementation of the provisions, including mortality review, quality and risk management, and Quality Service Reviews.

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



### **III. DISCUSSION OF COMPLIANCE FINDINGS**

#### **A. Methodology:**

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

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

During this tenth and eleventh review periods, the Independent Reviewer prioritized the following areas for review and evaluation:

- Serving Individuals with Complex Medical and Behavioral Needs;
- Behavioral Supports;
- Case Management;
- Crisis Services;
- Supported Employment;
- Independent Living Options;
- Transportation;
- Regional Support Teams;
- Quality and Risk Management;
- Office of Licensing Services-Office of Human Rights;
- Mortality Review; and
- Provider Training.

The Independent Reviewer retained thirteen independent consultants to conduct the reviews and evaluations of these areas. The Independent Reviewer modified both the span and process of the planned studies during the tenth and the eleventh review periods. Each was designed as a yearlong study that would be conducted in two phases. The first phase of each study was conducted during the tenth period; the second phase was completed during the eleventh review period. The consultants' reports of the first phases included *Findings* only; these were shared with the Commonwealth and with the Department of Justice. After conducting the second phases, the consultants reported on their findings from both phases as well as their analyses and conclusions regarding the Commonwealth's progress toward achieving the requirements of the Agreement. The consultants' reports of these studies are included in the Appendices of this Report.

For each study, the Independent Reviewer requested that the Commonwealth provide specific documents and all related records that the Commonwealth maintains to confirm that it has properly implemented the requirements of the Agreement. Information that was not provided by the Commonwealth was not considered in the consultants' reports or in the Independent Reviewer's findings, conclusions, and determinations of compliance.

The Independent Reviewer utilized his Individual Services Review (ISR) study process and Monitoring Questionnaire to evaluate the status of services for a selected sample of individuals during the tenth and eleventh periods. By reviewing these findings, the Independent Reviewer has identified and reported themes. For this Report, the Individual Services Review study was focused on the status of services for individuals with complex medical and/or behavioral needs, as determined by the results of each individual's scoring on the Supports Intensity Scale (SIS) evaluations which placed them in the two highest levels of need; that is, level six for individuals with intense medical support needs and level seven for intense behavioral support needs. During the tenth review period, twenty-six individuals were selected randomly from the cohort of forty-six individuals with intense medical needs, who live in Regions I, III, or V. For phase two, twenty-five individuals were randomly selected from a cohort of forty-two individuals whose SIS evaluations indicated that they had intense behavioral needs. The individuals in both cohorts had service enrollment dates since the beginning of Fiscal Year 2016. A separate supplemental study was also conducted of the behavioral supports being provided to a subset of the sample of individuals with intense behavioral needs.

The other studies completed by the Independent Reviewer's consultants for this Report examined the status of the Commonwealth's progress toward achieving or sustaining compliance with specific prioritized provisions that were targeted for review and evaluation. The Independent Reviewer shared with the Commonwealth the planned scope, methodology, site visits, document review, and/or interviews and requested any suggested refinements.

The Independent Reviewer's consultants reviewed the status of program development to ascertain whether the Commonwealth's initiatives had been implemented sufficiently for measurable results to be evident. The consultants conducted interviews with selected officials, staff at the State and local levels, workgroup members, providers, families of individuals served, and/or other stakeholders. To determine the ratings of compliance, the Independent Reviewer considered information provided prior to October 30, 2017. This information included the findings and conclusions from the consultants' topical studies, the Individual Services Review study, planning and progress reports from the Commonwealth and other sources. The Independent Reviewer's compliance ratings are best understood by reviewing the comments in the Summary of Compliance table, the Findings section of this report, and the consultant reports included in the Appendix.

During the twelfth review period, the Independent Reviewer will study the status of the Commonwealth's progress toward achieving compliance with most provisions that were not studied during the tenth and eleventh periods. These provisions include: Individual and Family Support Program; Discharge Planning and Transitions from the Commonwealth's Training Centers; Transitions of children from living in Nursing Facilities and large Intermediate Care Facilities; CSB/DBHDS performance contracts, Crisis Services/trend of increased admissions of individuals with IDD to state-operated psychiatric and other hospitals; and Integrated Day Activities, including Supported Employment.

Finally, as required, the Independent Reviewer submitted this Report to the Parties in draft form for their comments. The Independent Reviewer considered any comments before finalizing and submitting this eleventh Report to the Court.

## **B. Compliance Findings**

### ***1. Providing Home and Community Based Services (HCBS) Waivers***

The federal Centers for Medicare and Medicaid Services Home and Community-Based Services 1915(c) waiver program provides community-based services as an alternative to living in an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID). Individuals with IDD may receive HCBS waiver-funded services once they are awarded a waiver slot. In the Agreement, the Commonwealth was required to create a total of 4,170 additional waiver slots; a minimum number of additional waiver slots was required in each Fiscal Year and in each of the following three categories:

- Community Living (formerly ID) waiver slots to enable to transition to live in the community individuals from Training Center and those under twenty-two years of age from large ICFs and nursing facilities; and
- Community Living (formerly ID) waiver slots to prevent the institutionalization of individuals with ID on the urgent waiting list; and
- Family and Individual Services (formerly Individual and Family DD - IFDD) waiver slots to prevent the institutionalization of individuals with DD on the waiting list.

Historically, there were problems with many aspects of the Commonwealth's former HCBS waiver programs. The waiver programs included a diagnosis-based split between the ID and DD waivers. Both waivers provided funding for an array of services. The former ID waivers, however, provided funding for residential services, whereas the IFDD waiver did not. The historic lack of access to waiver-funded residential services caused problems for individuals with DD; for example, some individuals with DD and complex behavioral needs were not able to transition from Crisis Stabilization programs because they did not have funding for a residential program. The diagnosis-based waivers created a bifurcated system that was confusing for families, especially those with children who were not yet diagnosed as ID. It was also inefficient for providers. Those which offered similar services to individuals with ID and DD had to operate under two sets of rules, regulations and monitoring systems. The pay rates for some essential services were significantly underfunded; and, the rate structure created financial incentives to congregate large numbers of individuals into segregated settings. Although, a waiver slot was intended to be a ticket to a wide array of services that could meet an individual's needs, families often found that the services that they most wanted, such as in-home nursing and behavioral supports, were not actually available.

Recognizing these problems, the Commonwealth identified HCBS waiver redesign as its primary strategy to come into compliance with the Agreement's requirements to meet individuals' needs in community settings to prevent the unnecessary institutionalization of individuals with IDD. After completing a multi-year planning process, the Commonwealth redesigned its HCBS waiver programs. It amended the former ID and IFDD waivers so that each allowed eligibility for individuals with ID or DD, other than ID. After the Commonwealth's amendments to its ID and IFDD waivers were approved, the Commonwealth posited that, because its redesigned waivers each now allows eligibility for individuals with either ID or DD, it is no longer required to create the promised number of slots in the waiver category that includes funding for residential services. It is the determination of the Independent Reviewer that the Commonwealth is in non-compliance if it does not create, during FY 2018, the required number of waiver slots for each of the three waiver categories cited above, as specified in III.C.1.a, b, and c.

The cost of the required number of waiver slots was a primary consideration of the Commonwealth's when it negotiated the Agreement. The average cost of a waiver slot that includes residential services is substantially greater than the average cost of slots that do not fund this more comprehensive array of services. The Commonwealth's amendment of the higher per-person cost ID waiver program to allow individuals with DD to have access to waiver-funded residential service options is not a basis for reducing the required number of slots that provide funding for residential services.

The Commonwealth created, or exceeded, the required number of slots in each category in each of the first six Fiscal Years. For Fiscal Year 2018, however, the General Assembly funded only eighty additional Community Living waiver slots that include waiver-funding for residential services. Therefore, the Commonwealth has created 245 fewer than the required number of waiver slots in the waiver program category that provides funding for residential services. The Commonwealth did create 319 more of the Family and Individual Services waiver slots than required as well as sixty new Building Independence waiver slots. Under the Agreement, the Commonwealth has created a total of 3,373 new waiver slots; 863 more than required. The table below shows a comparison between the number of slots that were required to be created and the number that the Commonwealth actually created for each Fiscal Year and in each waiver category.

<b>TABLE 1</b>								
<b>Waiver Slot Allocation Summary Fiscal Years 2012 - 2018</b>								
<b>Settlement Agreement – <i>required / actually created</i></b>								
<b>Fiscal Year</b>	<b>2012</b>	<b>2013</b>	<b>2014</b>	<b>2015</b>	<b>2016</b>	<b>2017</b>	<b>2018</b>	<b>Total</b>
Community Living Waiver (formerly ID) Training Centers	60/60	160/160	160/160	90/90	85/85	90/90	90/100	735/745
Community Living Waiver (formerly ID)	275/275	225/300 (**25)	225/575 (**25)	250/25 (**25)	275/325 (**25)	300/300	325/80	1875/1880
Family and Individual Support Waiver (formerly IFDD)	150/165	25/50 (**15)	25/130 (**15)	25/15* (**15)	25/40 (**25)	25/340** (**10)	25/344	300/1088
Building Independence Waiver							60	0/60
<b>Total</b>	<b>485/500</b>	<b>410/510</b>	<b>410/865</b>	<b>365/130</b>	<b>385/650</b>	<b>415/530</b>	<b>440/584</b>	<b>2910/3773</b>

\* From reserves

\*\* Additional 200 for individuals on the chronological Wait List for the Family and Individual Support/DD Waiver

\*\*\* Prioritized slots for children living in large ICFs and nursing homes.

The Commonwealth restructured its HCBS waivers, “to provide for a flexible array of community-based options with a rate structure that supports the cost of new and existing services and provides incentives to providers for offering expanded integrated options.” The Commonwealth expects that improved access and availability of support services for individuals with intense behavioral or medical needs will result in decreased demand for crisis intervention and institutional levels of care. During the tenth and eleventh periods, the Independent Reviewer's Individual Services Review studies found indications that the Commonwealth's shift to more individualized and more integrated service arrangements has begun. Many individuals' day services have transitioned from occurring in large congregated to integrated settings.

During the waiver redesign planning process, the Commonwealth retained a national consulting company to study Virginia's waiver rates compared to market rates for various staff roles and functions, including for "skilled nursing." The consulting firm determined that Virginia's rate for "skilled nursing" was substantially below the market rate. In Fiscal Year 2015, the firm recommended a substantial increase to \$45.53/hour. Since then, the Commonwealth has increased its rate for "skilled nursing" services. In Fiscal Year 2018, the Commonwealth's rate for "skilled nursing" is \$32.20/hour, 70% of the "market rate" for 2015. Many families caring for family members with complex medical needs continue not to be able to secure nurses to provide essential in-home nursing for their family members for the number of hours approved by the Commonwealth. Family members report similar difficulty in hiring direct support staff to work in their homes with their family member, and in being able to secure qualified behavioral support staff. There was no evidence found during the Independent Reviewer's studies during the that the implementation of redesigned waivers has improved the availability of in-home nursing services or the availability and adequacy of behavioral supports programming. In fact, the demand increased for crisis services and institutional level of care.

DBHDS reported during the ninth period that a few children had begun to use the prioritized waiver slots to transition from living in nursing homes and large ICFs. DBHDS expected that, with full implementation of the redesigned waivers, and its plan to facilitate transitions of these children, substantive change would occur by the Spring of 2017. DBHDS has reported, however, that only one child utilized a waiver slot to transfer from a nursing home during all of Fiscal Year 2017 and that only two children transferred during the first quarter of Fiscal Year 2018. Five children were reported to have utilized waiver slots to transition from large privately operated ICFs to the community since January 1, 2017, when the DBHDS began its initiative to provide waivers to allow these children to live in non-institutional settings. The total number of children living in these institutions has increased from 108 to 111. For nursing homes, DBHDS reports that since its initiatives began in December 2014 many children have been diverted successfully from being admitted to nursing homes and none have been admitted for long-term care.

During the thirteenth reporting period, the fall of 2018, the Independent Reviewer will monitor and report on the extent to which the Commonwealth's redesigned waivers are able to provide these critical services in order to achieve its goals and its compliance with provisions of the Agreement related to integration and the prevention of unnecessary institutionalization.

The Independent Reviewer's Individual Services Review studies have consistently found that waiver slots provide individuals and families with critical supports that significantly improve their quality of life and prevent institutionalization. Many families have waited for years "on a wait list" before their family member was awarded a slot. Since these 3,773 new slots have been created since Fiscal Year 2011, the census of the Training Centers has declined from 1084 to 269, as of September 30, 2017. However, the number of individuals who are eligible for the waivers, whose names have been placed on waiting lists, has significantly increased. As of the fall of 2015, the names of more than a thousand individuals had been added to the waiting lists in each of the previous four years. The widely publicized increase in the incidence of Autism Spectrum Disorders in recent decades has been, and will continue to be, a significant contributing factor to this increase. The table below shows that, between July 1, 2011 and October 23, 2015, there were significant overall increases in both the number of individuals with IDD (6,283 or 39.5%), and in the number of individuals on the waiting lists (4,457 or 77.1%). Since then, the annual increases have continued at approximately the same

pace. As of June 30, 2017, the number of individuals with IDD had increased further (9,386 or 59.5%) as had the number of individuals on the wait lists (6,392 or 77.1%).

<b># Individuals</b>	<b>7/1/11</b>	<b>7/1/11-10/23/15</b>	<b># change</b>	<b>% change</b>	<b>7/1/11-9/30/17</b>	<b># change</b>	<b>% change</b>
<b><u>Waiver Slots</u></b> (1)	9,035	11,490	+2,455	+27.2%	12,844	+3in,809	+42.2%
<b><u>Wait Lists</u></b> (5)	5,783	10,240 (3)	+4,457	<u>+77.1%</u>	12,175	+6,392	<u>+ 111%</u>
<b><u>Training Centers</u></b>	1,084	455	-628 (4)	-58%	269	-628 (2)	- 75.2%
<b><u>Total</u></b> (2)	<b>15,902</b>	<b>22,185</b>	<b>+6,283</b>	<b>+39.5%</b>	<b>25,288</b>	<b>+9,386</b>	<b>+59.5%</b>

Notes (1) All waiver slots are not being used on specific dates. Slots are held in reserve for emergencies and for individuals who will transition from Training Centers, Nursing Facilities, and large ICFs.

(2) The total number of individuals is the sum of the numbers: of slots, on waiting lists, and living in Training Centers

(3) The decline in the census at the Training Centers is greater than the number of individuals who moved to live in community settings. The two primary reasons for the difference are that 134 residents of Training Centers on June 30, 2011 had died by September 30, 2017 and some residents were discharged to skilled nursing facilities.

(4) All individuals have a level of need that makes them eligible for institutional care.

(5) More than a third of these individuals are receiving some services through either the EDCD or Tech waivers.

In the four-year period between July 2011 and October 2015, the increased number of individuals with IDD who met Virginia's comparatively strict Medicaid eligibility standards increased at a much faster pace than the number of newly created waiver slots. While the number of waiver slots increased by 636 per year, the number of individuals on the waiting lists continued to increase by more than 1,114 per year. Although some expected that the growth in the waiting lists would slow, this has not occurred. Since 2015, an annual average of 677 additional slots have been created for individuals on the wait lists; the number of eligible individuals on the waiting lists also increased by 967 per year. Since July 2011, some of the individuals who have been awarded slots have been able to transition to live in the community from living in institutions; i.e. Training Centers, large private operated ICFs and nursing facilities. In these six and a quarter years, since the Settlement Agreement commitments began, there has been an overall increase of 9,386 individuals with IDD who either live in Training Centers, have waiver slots in the community, or who are on waiting lists. In July 2011, there were 15,902 individuals; as of September 2017, there are 25,288, a 59.5% overall increase.

The Commonwealth is in compliance with Section III.C.1.a.vii.

The Commonwealth is in non-compliance with Section III.C.1.b. vii. It is in non-compliance with the qualitative aspects of both III.C.1.b. and III.C.1.c. The Commonwealth had not yet created the required number of slots in the Community Living waiver category, which provides waiver-funding for a more comprehensive array of services.

## **2. *Serving Individuals with Complex Medical and Behavioral Needs***

The Individual Services Review studies during the tenth and eleventh periods studied the service outcomes for individuals with intense service needs. For the tenth review period: individuals who scored a level 6 (intense medical needs) on the SIS evaluation, were living in Regions I, III, or V, and were newly enrolled in the Waiver-funded services between June 2016 and May 2017. All scored a level 6 on the SIS. For the eleventh review period: individuals scored a level 7 on the SIS, were living in Regions I, III, or IV, and were enrolled in the Waiver between July 2015 and December 2016. Therefore, all individuals studied had the highest level of need in terms of either intense medical/healthcare need (level 6) or behavioral need (level 7).

### **Themes from the ISR Studies during the tenth and eleventh review periods**

Although there were individual exceptions, the two studies identified the themes listed below:

#### *Positive Findings:*

Receiving HCBS Waiver slots and Waiver-funded services has significantly improved the quality of life for individuals with urgent and complex medical and/or behavioral needs and their families.

Overall, the individuals' support plans were current and were person-centered. Case Managers typically documented making the required onsite visits, including those to the individuals' homes, as based on the level of case management specified. Additionally, Case Managers often documented many other collateral contacts.

In the more densely populated Tidewater area, there were sufficient medical resources to allow the ten individuals in the sample with complex medical needs to live with their families. The necessary assessments, consults and treatments were provided for/to these individuals.

Five sponsored residential homes were providing good quality supports to individuals, including those with the most intense support needs. The individuals living in these homes received strong supports, more integration opportunities, and a higher quality of life than most of the individuals in the samples who were living in congregate residential programs. Of the fifty-one individuals whose services were studied, twenty-one did not live in their own or family home. Of these twenty-one, only one quarter were living in sponsored residential homes.

#### *Areas of Concern:*

Many individuals, with Waiver funding, who lived in group homes or in their families' homes lacked adequate services. Their Case Managers, who identified the absence of needed services, frequently were not able to resolve the obstacles. Examples of gaps in services/supports include the inability to secure or maintain needed and qualified behavioral supports, in-home nursing services, in-home direct support professionals and needed equipment. Some Case Managers did not identify needed assessments or inadequately delivered services. Those who included such observations in their notes were frequently not able to resolve the issue. For example, in the months following the Case Manager's notes that data were not being collected as needed regarding implementation of an essential behavior plan, there was no evidence that the author of the behavior plan or the residential service provider made the necessary and expected changes. There also did not appear to be a mechanism to report systemic obstacles to receiving needed and appropriately delivered services to the Commonwealth so that appropriate and timely action could be taken by relevant officials.

In rural areas many individuals, with identified needs, lacked available and accessible healthcare. In all areas of the Commonwealth behavioral support services did not meet generally accepted practices. It was reported that there was a lack of community clinicians with expertise and familiarity with individuals with I/DD. This appeared to be particularly true for in-home nursing and Board-Certified Behavior Analysts.

Structured behavioral supports that met generally accepted practices were not provided to individuals with aggressive, dangerous, and disruptive behaviors that negatively impacted their ability to learn new skills, impeded their ability to participate in their communities, reduced their quality of life, or impeded their progress in becoming more self-sufficient. The supports being provided frequently lacked the essential elements expected of good quality behavioral programming. The missing elements included a functional behavior assessment in the current setting, data collection to determine whether planned interventions are working, or the identification of replacement behaviors and new adaptive skills to be learned.

Providers and families experienced great challenges finding and retaining in-home nurses and direct support professionals who would work for the currently available low rates of pay. In rural areas, families frequently reported that the additional high cost of travel and extended unpaid travel time added to the challenge of recruiting and retaining qualified staff. A few cases were found in rural areas of support staff who had served the same individual for several years and knew him/her very well.

For many of the individuals studied, the Case Managers did not fulfill several requirements of the Agreement. These requirements included:

- The outcomes in ISPs were not specific and measurable;
- A choice of Case Managers was not offered or was contingent on the AR first expressing dissatisfaction with the current Case Manager's performance;
- ISPs were not modified as necessary in response to major life events;
- Employment service goals were not developed and discussed;
- Integrated day opportunities were not offered; and
- Some Case Managers did not take an active role in assisting individuals to gain access to needed services, including adaptive equipment.

Case Managers did not appear to have the expertise, or ready access to needed clinical expertise, to identify certain health care and behavioral service needs, the need for assessments in these areas, or the required elements of effective related protocols/supports. For individuals in need of behavioral programming, many Case Managers did not identify that the programming currently in place lacked key elements essential to appropriate implementation. There also appeared to be a systemic obstacle to assembling clinicians with specialized knowledge so that the ISP Team could benefit from the expertise and experience of these credentialed professionals when it met to develop the goals and expectations for behavioral programming that would meet generally accepted practices.

The lack of dental care remains a concern for approximately one third of the individuals visited. In addition, of the individuals who were receiving dental care, more than one-third had not had the dentist's recommendations implemented within the time frame recommended.



### **3. Behavioral Programming and Supports**

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

These components included:

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

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

- Eight (100%) engaged in behaviors that injured self or others;
- Eight (100%) engaged in behaviors that disrupted the environment;
- Seven (88%) engaged in behaviors that impeded his/her ability to access a wide range of environments; and
- Six (75%) engaged in behaviors that impeded their abilities to learn new skills or generalize already learned skills.

#### *Positive Findings:*

- Most of the five BSPs identified potential antecedents and consequences of target behaviors as well as contained proposed hypotheses regarding the underlying function(s) of behavior. These BSPs identified a method of measurement for target behaviors as well as described data collection procedures, including when the author was expected to summarize and analyze target behavior data.
- All of the BSPs included environmental modifications and supervision strategies aimed at preventing or reducing the likelihood of maladaptive behavior, as well as proactive and reactive strategies aimed at preventing and responding to target behavior. The BSPs identified potential reinforcers and prescribed the use of positive reinforcement.
- Some of the BSPs included specific strategies designed to promote skill acquisition (i.e. more adaptive responses).

#### *Areas of Concern:*

- Of these eight individuals, however, only five (63%) individuals were receiving formal behavioral programming through Behavior Support Plans (BSPs) at the time of the on-site visit. Overall, all (100%) of the individuals sampled appeared to demonstrate significant maladaptive behaviors that negatively impacted their quality of life and greater independence. Consequently, it appeared that all of these individuals would likely benefit

from positive behavioral programming and supports implemented within their homes or residential programs.

- Of the five (63%) individuals who had BSPs, the BSPs for two (40%) of these individuals had not been revised as planned, during their transitions from Training Centers, after sixty days in their new setting. More troubling was the fact that the development and implementation of a BSP for one individual was inexplicably delayed for almost one-year after her admission to a group home.
- Only three (60%) of the eight individuals appeared to have had Functional Behavior Assessments (FBA) completed within their current settings. When closely examined, of the three FBAs, only two (66%) appeared to have been completed using descriptive methods consistent with generally accepted practice recommendations.
- Of the five BSPs, the prescribed behavioral programming appeared inadequate (see Individual Summary of Findings for specific information). For example, although all of the BSPs identified target behaviors for decrease, none (0%) of the BSPs clearly identified and operationally defined specific functionally equivalent replacement behaviors (FERB), which are generally considered necessary for efficient and effective behavioral programming. Although evidence was provided demonstrating ongoing data collection and review of target behaviors for two (40%) of these five individuals, evidence that similar data collection and regular review were completed for functionally equivalent replacement behaviors was not found for any (0%) of the individuals sampled. Overall, of the individuals sampled, zero (0%) appeared to have adequate behavioral programming in place consistent with standards of acceptable or expected practice. Only two (40%) of the five BSPs had been developed and monitored by a Board-Certified Behavior Analyst (BCBA).

*Conclusions:*

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

#### **4. Case Management**

Case Management is the most important single resource for individuals served and their families. Accordingly, the first service listed in the Settlement Agreement assigns the Case Manager responsibility to assemble the Individual Support Team to develop the support plan for the individual; to assist the individual and family to gain access to needed services; and to monitor service delivery and to make service changes, as needed. Because of the central importance of the Case Manager to the individual and family, the Agreement also includes provisions to ensure that:

- Case Managers do not have a conflict of interest;
- Individuals and families are offered a choice of, and can change, Case Managers;
- Case Managers offer education about less restrictive community options annually to any individual living outside their own or family's home;

- 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, as necessary, assemble the ISP team to address the concern and to document its resolution;
- There is a licensing process that assesses the adequacy of individualized supports; and
- The Commonwealth establishes a mechanism to monitor the delivery of Case Management services to ensure that they comply with performance standards.

The Independent Reviewer retained a team of independent consultants to complete a year-long two-phase evaluation of the Commonwealth's compliance with the Agreement's Case Management provisions. During each phase of their study, the consultants focused on more than forty individuals with intensive needs. The first phase of the study focused on individuals with complex medical needs; the second on individuals with intensive behavioral challenges. Each review included at least a qualitative review of the Individual Support Plan (ISP) and recent Case Manager/Support Coordinator progress notes. They also conducted a discrepancy analysis to determine what gaps exist between the individual's assessed needs and ISP goals, as documented in the Case Management/Support Coordination system reports and documents, and the services and supports that were actually being provided.

The discrepancy analysis suggested that the most frequent shortcomings in the Individual Support Plans remains:

- ISP has specific and measurable outcomes.

Other significant systemic trouble spots were:

- Documentation of being offered choice to change Case Managers/Support Coordinators;
- Employment services and goals must be developed and discussed;
- Modifying the ISP as needed;
- All essential supports listed in ISP.

These findings of the Case Management study are consistent with the findings of the Individual Services Review study. Both studies found that the Commonwealth had addressed and resolved a previously identified trouble spot: the annual offer of education "about less restrictive community options to any individual living outside their own or family home." This offer is now documented in the ISP which is reviewed, and if approved, is signed by the individual or his/her Authorized Representative.

Finally, DBHDS has proposed that its Data Dashboard serve as the systemic measurement of the achievement of goals in the Agreement. Previous studies by an independent consultant have raised concerns about the use of the Data Dashboard reporting as a response to the Agreement's requirements to report data. DBHDS has made efforts to drill down on these reporting issues and has identified some potential sources of the unreliable data and the under-reporting. To improve the reliability of the information in the Data Dashboard, DBHDS staff have worked to improve CSB data entry rates. However, this period's review identified eleven CSBs which have not met the DBHDS face-to-face goal of 90% since 2015. DBHDS has identified flaws in electronic data interfaces that may account for some of this under-reporting. DBHDS projects that the system improvements associated with the interfaces should be evident later in Fiscal Year 2018. It is not

clear, however, that the issue of complete and accurate reporting will be fully resolved through the implementation of data entry edits and improved electronic interfaces. While the Data Dashboard reports that most CSBs have achieved 90% or better on the critical measure of face-to-face visits, eleven (11) CSBs did not report over 86% between October 2015 and March 2017. This suggests the possibility that, in these eleven underreporting CSBs with an extrapolated enhanced Case Management caseload of 1,547, at least 217 individuals each month may have not received the monthly face-to-face visit required under Enhanced Case Management or, alternatively, that their face-to-face visits may have occurred, but not have been reported or registered. It is important to note that the statewide average on this measure does not appear to have improved much beyond 86% for the past two years, probably because of reported under-performance of these eleven CSBs.

The consultants found that, during the tenth and eleventh periods, DBHDS had exerted concentrated efforts on additional Case Manager/Support Coordinator training. It has also generated an invigorated emphasis on supporting Case Managers/Support Coordinators in the Provider Development Section of the DBHDS, Division of Developmental Services. To improve future Case Management performance, DBHDS has contracted for support from Virginia Commonwealth University (VCU) to complete a manual, a supervisory review tool, core competencies and to update the Case Management Modules for online training.

The Commonwealth is in compliance with Section V.F.1 and 3.  
The Commonwealth remains in non-compliance with V.F.2.

## **5. Crisis Services**

For the tenth and eleventh review periods, the Independent Reviewer retained an independent consultant to complete a year-long two-phase study of the Commonwealth's crisis services system. This review gathered facts and analyzed the Commonwealth's status toward implementing the following Agreement requirements that the Commonwealth:

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

All areas of the crisis services requirements for both children and adults were reviewed regarding accomplishments and compliance. The consultant's review included a qualitative assessment of the crisis supports and other needed and related community services for thirty-six individuals who were referred to REACH. The review was intended to determine what services were needed and provided, how effective the supports were and whether community service capacity is sufficient to assist individuals to remain in their homes with appropriate ongoing services.

The consultant's review focused on:

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

In prior Reports to the Court, the Independent Reviewer has reported compliance with the Agreement's crisis services provisions *based only on the statewide crisis services for adults*. In this Report, however, the Commonwealth's compliance with the Agreement's crisis services requirements are based on the status of these services for both children and adults.

In Fiscal Year 2012, prior to the reaching a settlement and a year before the Agreement was approved by the Court, the Commonwealth had funded and begun development of its crisis services for adults only, a substantial undertaking in itself. The Independent Reviewer monitored the status of the Commonwealth's development of the new crisis services for adults and determined compliance with the crisis services provisions based only on the status of these services for adults. In this Report, however, and for the first time, the Independent Reviewer has made compliance determinations with consideration of the status of the Commonwealth's crisis services for the entire target population including children, adolescents and adults. Because the Commonwealth has separate crisis services programs (REACH) for children in two of its Regions, the consultant continued to gather and report information separately for children and adults (See Appendix 4, "Crisis Services Requirements" for detailed information.)

The status of the crisis services system components that the Commonwealth committed to provide is as follows:

### **Crisis Point of Entry**

The REACH programs, both for children and adults, in all Regions continue to be available twenty-four hours each day and to respond onsite to crises. The Commonwealth continues to utilize CSB Emergency Services as one means to access information. REACH hotlines are also operated twenty-four hours per day, 7 days per week for adults and for children with IDD. The number of crisis referral calls continues to increase.

The REACH programs have continued to train CSB Emergency Services staff in each Region. The Children and Adult REACH teams trained 705 CSB employees and 186 CSB Emergency Services staff during the eleventh review period.

## Mobile Crisis Teams

The REACH Mobile Crisis Team members continue to be trained by either the National Center for START Services or through similar training using a curriculum reviewed and approved by DBHDS. The DBHDS standards for the REACH programs require comprehensive staff training with set expectations for topics to be addressed within 30, 60 and 120 days of hire. Staff must complete and pass an objective comprehension test. Ongoing training is required and each staff must have clinical supervision, shadowing, observation and must conduct a case presentation and receive feedback from a licensed clinician on their development of Crisis Education and Prevention Plans.

However, the facts gathered indicate that this training has not been sufficient in several areas. For example, REACH staff are charged with de-escalating crises without removing individuals from their current home setting, yet REACH assesses most of the individuals after they been transported from their home to the hospital. A significantly higher percent of these individuals are hospitalized. The Commonwealth reports that the number of individuals with IDD who are removed from their home setting continues to increase. For example, there were 426 admissions of adults to state operated psychiatric hospitals during the second half of Fiscal Year 2017, twenty-six percent more than the 339 admissions during the previous six months. This increase occurred during a period when REACH staff were involved with the pre-admission screening of an increased percentage of the individuals who were admitted. DBHDS reported that 207 admissions of children to state operated psychiatric hospitals during the eleventh reporting period. This is a 51% increase over the 137 such admissions during the tenth period, which was a 37% increase over one hundred admissions in the ninth period. As some children may have been admitted more than once, the number of admissions exceeds the number of different individuals who were admitted. The Commonwealth cannot determine the number of different individuals with IDD who were admitted to its state operated facilities. The Independent Reviewer's studies have also found a substantial number of families refused REACH services after completing the initial process. For children, the consultant found that the REACH crisis services did not result in reducing the percent of children who were hospitalized at the time of the crisis assessment.

This reported increase in admissions to psychiatric admissions during Fiscal Year 2017 occurred after the REACH programs for children and adults were fully operational, providing supports and services intended to de-escalate crises without removing individuals from their current placement. The Independent Reviewer has not determined that REACH staff did not make valiant efforts and cannot determine what percentage of these admissions was clinically appropriate, but the expected and desired outcome of this provision has not been achieved. Of the reported increase in the number of individuals admitted to psychiatric institutions, thirty-nine percent were previously known to REACH, sixty-one percent were new cases. The increase in admissions of those known to REACH is an indication that the REACH prevention plans and treatment strategies for preventing future crises had not been effective in achieving the planned outcome of preventing future crises for these individuals. The increase in admissions may also reflect the way the Commonwealth has structured and implemented its CSB Emergency Services assessment process for admission to state-operated psychiatric facilities. The Commonwealth's system results in most REACH assessments occurring after the individual has been taken to the hospital. This arrangement results in REACH assessing whether the individual can be supported in his or her home after the individual has been removed from the home to be taken to the hospital. The Commonwealth reported that 37% (176/479) of children were admitted to state-operated psychiatric hospitals at the time of the

REACH assessment, compared with 15% (55/367) who were admitted after receiving REACH mobile crisis services. For adults with IDD 31% (314/1001) were hospitalized at the time of the REACH assessment, compared with 4% after receiving REACH mobile crisis supports. The Commonwealth should carefully study the root causes of 37% of children and 31% of adults being admitted to psychiatric hospitals after their initial interaction and assessment by REACH.

The Commonwealth reported that 37% (176/479) of children were admitted to state-operated psychiatric hospitals at the time of the REACH assessment, compared with 15% (55/367) who were admitted after receiving REACH mobile crisis services. For adults with IDD 31% (314/1001) were hospitalized at the time of the REACH assessment, compared with 4% after receiving REACH mobile crisis supports. The Commonwealth should carefully study the root causes of 37% of children and 31% of adults are admitted to psychiatric hospitals after their initial interaction and assessment by REACH.

The consultant also reported that the families for five of twenty individuals (25%) in a randomly selected sample of individuals refused to continue REACH services. These families had been referred to REACH, and had completed the intake process and the development of an interim or full Crisis Education and Prevention Plan,. This unexpected high percentage of refusals, coupled with an increased number of admissions to psychiatric facilities, should be carefully studied by the Commonwealth to determine its root causes and whether these causes can be more effectively addressed by improved training. Families of children with intense behavioral needs, who were interviewed during the Individual Services Review process, reported that the REACH services for their children had limited value. These families emphasized the need to have a place where their children could stay overnight on occasion to give them a break from their twenty-four hour a day responsibilities for a child who demonstrates dangerous and destructive behaviors, often during overnight hours.

### **Response Times**

Mobile crisis teams for children and adults responded to more than 95% of all crisis calls within two hours and to 71% within one hour. All Regions achieved average annual response times of less than two hours in areas designated as “rural” and less than one hour in areas that the Commonwealth designated as “urban”.

### **Crisis Stabilization Programs**

The Commonwealth has continued to provide a statewide crisis stabilization program. Each Region provides a six-bed crisis stabilization home, which DBHDS now calls Crisis Therapeutic Home (CTH). These homes offer short-term alternatives to living in an institutional setting for adults.

The Commonwealth still does not provide crisis stabilization homes for children in any of the Regions. In the Agreement, the Commonwealth committed to develop such programs for children as of June 30, 2012. The Commonwealth’s development of crisis services, and crisis stabilization homes, was underway for adults before the Settlement was reached. DBHDS later determined that it would be inappropriate to provide crisis stabilization services for children in the same home with adults, many of whom exhibit challenging behaviors. Eventually, DBHDS issued an RFP, on May 1, 2016, to develop and begin out-of-home crisis respite services during Fiscal Year 2017. There is also funding available to develop two homes in the Commonwealth; each with the capacity to serve

six children. DBHDS believes that these two homes when supplemented with respite services and therapeutic host home options will be sufficient to meet the needs of children who need time out of their family homes to stabilize. DBHDS did not receive suitable responses, however, from prospective providers to its initial RFP. At the time of this review, DBHDS was in the process of finalizing contracts with recently identified providers.

In the spring of 2017, DBHDS reported that out-of-home respite services will be available in the Fall of 2017 and that two CTHs will open early in calendar year 2018. However, these scheduled developments have both been delayed. The planned opening of the two CTHs for children is now delayed until the end of Fiscal Year 2018. The design of these two new CTHs will be based on the existing architectural plan of the Region IV CTH for adults. The sites for both of the new CTHs have been selected. The Richmond and Rappahannock/Rapidan CSBs will operate these two crisis stabilization homes. DBHDS is planning to execute sole source contracts for the out-of-home therapeutic respite, because it did not receive suitable responses to the RFP. DBHDS is now projecting that these services will become available as early as January 2018, but no later than June 2018.

### **Crisis Stabilization: Length-of-Stay for Adults**

The Crisis Stabilization Programs (CTHs) were designed to offer short-term alternatives to institutionalization. Stays greater than thirty days are not allowed. The premise for capping the length of stay is that the setting is most effective as a short-term crisis service. The Independent Reviewer has previously determined that the Commonwealth is not in compliance with this requirement because many lengths of stay have exceeded the thirty-day maximum allowed. The Commonwealth had determined that additional homes were required for individuals who needed temporary housing for up to six months to make a positive transition to a new permanent residence. DBHDS has not been able to open the two transition homes for adults that it had planned. It now anticipates opening the homes by the end of Fiscal Year 2018.

The REACH crisis stabilization homes continue to have individuals who stay longer than the thirty-day maximum allowed. Therefore, the Commonwealth remains in non-compliance. The REACH Teams, however, have substantially shortened the average length of stay. The final three months of the eleventh review period was the first quarter in which the average in every Region has not exceeded the 30-day expectation. With shorter average lengths of stay, the CTHs have been available for more individuals who require crisis stabilization, prevention, or step-down from psychiatric hospitalization.

DBHDS did not have sufficient capacity in its five Crisis Stabilization Programs. Individuals with IDD, who were ready for discharge, continued to be institutionalized as a result of a lack of available beds in the existing Crisis Stabilization Programs (CTH). Evidence that supported this concern was also found in the clinical case reviews completed for twenty selected adults, in the tenth review period, who were referred for crisis services. The regional REACH teams all acknowledged that it might have been possible to divert some individuals who were hospitalized, if the CTH had an opening



## **6. *Integrated Day Activities and Supported Employment***

As required by the Settlement Agreement, the Commonwealth established the state Employment First policy for the target population. It has been included as a requirement in the CSB Performance Contract requiring application of this policy.

During the tenth and eleventh review periods, the Independent Reviewer retained ten independent consultants to complete three studies related to employment requirements of the Employment First policy and the Integrated Day Activities and Supported Employment provisions of the Settlement Agreement. Each study reviewed aspects of the Commonwealth's progress and status toward achieving these requirements. During the tenth and eleventh periods, the Individual Services Review and the Case Management studies both included focus, respectively, on the extent to which Case Managers effectively implemented these requirements for individuals with complex medical and behavioral needs, if these individuals were between eighteen and sixty-four years of age. Both studies determined whether Case Managers implemented the principle that individual supported employment was the first and priority service option for the individuals they support and whether "employment services and goals" were "developed and discussed at least annually," with the individual, his/her Authorized Representative and, if so, whether employment service and goals were included in the ISP.

The third study of Integrated Day Activities and Supported Employment focused on the following:

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

(Note: The reports of these studies are included in Appendix A, C, and E.)

The eleventh period's Individual Services Review and the Case Management studies found that, of the forty individuals (age 18-64) reviewed, employment services and goals were not developed or discussed with fifteen individuals (40.0%). Case Managers frequently checked boxes in the ISP document indicating that employment had been discussed. There was no evidence, however that that possible employment goals were developed and discussed to ensure that there was a meaningful, rather than a cursory, discussion. Of the twenty-five individuals with whom employment goals were developed and discussed, nine (36%) had employment goals included in their ISPs..

The Commonwealth is in non-compliance with III.C.7.b.

### **Integrated Day Activities Plan**

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.”* One of the component provisions included in the Agreement to support achievement of this overarching goal requires, *“Within 180 days of this Agreement, the Commonwealth shall develop, as part of its Employment First policy, an implementation plan to increase integrated day opportunities for individuals in the target population, including supported employment, community volunteer activities, community recreational opportunities, and other integrated day activities.”*

The Commonwealth met the 180-day timeline; its plan, however, focused only on increasing employment opportunities for individuals with IDD. The Independent Reviewer directed DBHDS to develop a plan by March 31, 2014 to describe its approach to create integrated day activity programs, including developing the capacity throughout its provider community to ensure that individuals in the target population, who were not engaged full-time in employment services, could participate in *community volunteer activities, community recreational opportunities, and other integrated day activities* as the foundation of their day programs. The Commonwealth submitted the requested plan.

The Independent Reviewer determined, however, that it did not include all essential elements of an effective plan, such as strategies, goals, action plans, interim milestones, resources, responsibilities and a timeline for statewide implementation. During this review period, DBHDS submitted its revised plan for providing integrated day activities, “Community Engagement Plan FY2016-FY2018,” which includes status updates through the first quarter of Fiscal Year 2018. The foundation for providing integrated day activities, which DBHDS now calls “community engagement,” is its plan to implement its redesigned HCBS waivers, through which the Commonwealth will offer community engagement, community coaching and related services with reasonable rates.

### **Waiver Redesign**

The Commonwealth submitted its HCBS waiver amendments to CMS in March 2016. The federal Center for Medicare and Medicaid Services (CMS) approved the Commonwealth's amendments for implementation during Fiscal Year 2017. The Commonwealth's General Assembly, however, delayed implementation of two employment-related services, benefits planning and non-medical transportation, until Fiscal Year 2018. DBHDS had planned to submit amendments to initiate transportation, community guide and benefits planning in October 2017; however, it now projects that submission will occur in December 2017. DBHDS projects that these services will become

available before the end of Fiscal Year 2018. The actual date of availability will depend on when the application is submitted and the length of time required to secure CMS approval.

During the tenth and eleventh review periods, the Commonwealth has implemented its approved redesigned HCBS waiver amendments for serving individuals with I/DD. With the input of the Community Engagement Advisory Group, DBHDS drafted a comprehensive Community Inclusion Policy. This policy sets the direction and clarifies the values of community inclusion for all individuals with IDD, regardless of the severity. The policy requires the involvement of both DBHDS and the CSBs:

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

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

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

1. There is an overall goal to develop a common understanding and philosophy among stakeholders, providers, and state agencies of Community Engagement (CE) based on accepted national standards and in compliance with federal regulations. Policies will be established to promote and encourage CE Activities.
2. Develop funding sources that promote and encourage implementation of CE.
3. Ensure that structures, at both the state and provider level, will support delivery of CE in the least restrictive and most integrated settings that are appropriate to the specific needs of the individual, as identified through the person-centered planning process.
4. Ensure CE services are being offered and provided to individuals across the state in the most integrated community settings, based on the needs of the individual, as determined through the person-centered planning process.
5. Ensure that there is an increase in meaningful CE for each individual. Virginia's vision is to have an array of integrated service opportunities available for individuals with disabilities and wants individuals to be able to choose to have services delivered to them in the least restrictive and most integrated setting.

The status report as of progress toward achieving the goals of the Community Engagement Plan, as of September 2017, is included in the consultant's report (Attachment E).

DBHDS and the CEAG have developed a robust definition of Integrated Day Activities, which it now calls Community Engagement. These services have been approved by CMS and offered to waiver participants since September 2016. There is a total of 8981 individuals authorized for waiver-funded day services including center-based day services. As of June 30, 2017, 1708 (19%) of these individuals are authorized for CE and community coaching. This significant increase, in a nine-month period, illustrates a strong interest among individuals and families. With 183 licensed provider locations of community engagement (non-center based day), it is clear that the provider community is responding to the direction set by DBHDS to transition its system of day supports away from large and segregated congregate center-based settings to services that support individuals with I/DD to participate in inclusive community opportunities. Transportation, which is included but not yet available, will be a key element to successfully offering these services.

During the tenth and eleventh review periods, DBHDS and the CEAG improved its Community Engagement plan, did considerable work that achieved important milestones and implemented new community engagement services for hundreds of individuals.

As a result, the Commonwealth has newly achieved compliance with *III.C.7.b.i.*

### **Regional Training on the Employment First Policy**

DBHDS provided significant training regarding the Employment First policy and strategies throughout the Commonwealth during several consecutive review periods. These trainings, as well as technical assistance to Employment Service Organizations (ESOs), continued during the tenth and eleventh review periods. Fewer trainings were provided, however, because DBHDS focused intensely on providing training related to implementation of the newly approved Community Engagement services. DBHDS does plan to hold town hall meetings throughout Virginia in the Spring of 2018 for families and individuals. The town hall meetings will be related to the Employment First policy and strategies related to addressing attitudinal, cultural and environmental barriers to employment from the perspective of the individual.

The Commonwealth has sustained compliance with *III.C.7.b.i.A.*

### **Establishing Baselines and Targets to Increase Supported Employment**

As previously reported, the Commonwealth established baselines for the number of individuals receiving supported employment services through the HCBS waivers, the length of time these individuals maintain employment in integrated settings, the amount of earnings from supported employment, the number of individuals receiving pre-vocational services, and the length of time people remain in prevocational services.

The Commonwealth is in, and will remain in, compliance with *III.C.7.b.i.B.1.a.-e.*, as it has fulfilled the requirements of these provisions.

The Commonwealth also previously set employment targets for two groups: 1. individuals with IDD with HCBS waiver-funded services, and for 2. the larger group that also includes individuals on the IDD waiting lists. Compliance determinations for the provisions related to supported employment have been, and will continue to be, based on the smaller group of individuals with IDD HCBS waiver-funded services, as required by the Agreement. The individuals with waiver-funded services

tend to have greater needs than the larger group that includes individuals on IDD waiting lists. The Independent Reviewer's compliance determinations for the employment related provisions are also based on the Commonwealth's effectiveness at achieving these targets to meaningfully increase participation in supported employment for individuals who are eighteen to sixty-four years of age, with a goal of earning minimum or competitive wages.

The Commonwealth set targets on June 30, 2015 for June 30, 2019. The target set for the larger group of individuals was that 25% of them would be employed, in either Individual or Group Supported Employment (i.e., 3,935 of 15,739 individuals). As of June 2017, 3,806 individuals are so employed, or 24% of 15,739. This increased number of individuals with IDD who are employed is evidence of steady progress. This number of employed individuals is an increase of 234 individuals in Individual or Group Supported Employment since December 2016. Twenty-four percent employed represents steady and excellent progress over the past three six month periods, when twenty percent were employed in December 2015, twenty-two percent in June of 2016 and twenty-three percent in December 2016.

The Commonwealth's progress toward achieving its targets to increase the number of individuals who are employed through HCBS waiver-funded programs, however, has significantly slowed. The targets depicted in the table below are for the total number of individuals with waiver funded services in Individual and Group Supported Employment for each of five Fiscal Years. DBHDS and the Supported Employment Leadership Network VA set these targets in March 2014.

<b>TABLE 3</b>			
<b>Employment Targets in HCBS Waiver Programs: FY16 – FY20</b>			
<b>End of FY</b>	<b>ISE</b>	<b>GSE</b>	<b>Total</b>
16	211	597	808
17	301	631	932
18	566	731	1297
19	830	831	1661
20	1095	931	2026
<b>Total Increase FY '16- '20</b>	<b>884</b>	<b>334</b>	<b>1218</b>

As of June 2017, 826 individuals were participating in HCBS waiver-funded Individual or Group Supported Employment. This is eighteen more than the target for June 2016 but only fourteen percent of the planned target increase of 132 participants between June 2015 and June 2016, and 106 fewer individuals than the target of 932. As of December 2016, more individuals were employed than the Commonwealth's targets for the end of Fiscal Year 2017. However, by June 2017, there were nearly 100 fewer individuals in supported employment programs. The dramatic slowdown in the Commonwealth's progress toward achieving its employment targets is an indication of systemic obstacles. The Commonwealth will need to identify, address and resolve such obstacles if it is to meaningfully increase the number employed by June 2018 to achieve the target of 1,297 individuals employed.

The Commonwealth is not in compliance with *III.C.7.b.i.B.2.a.*, as it has not made sufficient progress toward achieving its target for individuals in HCBS waiver-funded services; and, it has not yet addressed systemic obstacles needed to continue to meaningfully increase the number of individuals participating in waiver-funded supported employment.

### **Length of Time Employed**

The Commonwealth established the target of eighty-five percent of individuals with disabilities would “remain employed in integrated work sites for one year or more after the start of supported employment.” The Commonwealth exceeded this expectation in the tenth reporting period. Eighty-seven percent of individuals reportedly worked at their job for one year or more in ISE, as did ninety-six percent in Group Supported Employment (GSE). This changed, however, in the eleventh reporting period. While ninety-five percent of individuals in GSE had been employed in their job for one year or more, only eighty percent of individuals in ISE were so employed. Overall, eighty-four percent of individuals were continuously employed in the current position.

The Commonwealth is in compliance with *III.C.7.b.i.B.2.b.*

### **Regional Quality Councils**

All five Regional Quality Councils met in both quarters of the eleventh review period. Employment data were presented. The RQCs completed the required annual review of the employment targets during the tenth reporting period. Additionally, the statewide Quality Improvement Committee had a meaningful discussion about the employment targets at its meeting in June 2017 and made recommendations that were shared with the Employment First Advisory Group.

Attendance records and minutes of the RQC meetings reflect a lack of engagement of individuals, families and employment providers in Committee meetings. Stakeholder membership and participation in the RQCs ensures that local and regional concerns and recommendations for quality improvement are being reviewed, refined, and recommended to the Quality Improvement Committee. Limited stakeholder participation is a current obstacle to the RQCs being able to effectively fulfill their designated role in the DBHDS quality improvement process.

DBHDS is in compliance with *III.C.7.d.*

## **7. *Independent Housing***

The Independent Reviewer retained the same independent consultant who previously reviewed the status of Virginia’s *Plan to Increase Independent Living Options* in November of 2013 and November 2014. For this review, the consultant completed a year-long two-phase study. In June 2017, the consultant found that the Commonwealth had made substantial progress, as the DBHDS independent housing development was ahead of its development schedule. At that time, he noted concerns about whether DBHDS and its Regional Housing teams were tracking the development of units set aside in the 2015 Low Income Housing Tax Credit Program (LIHTC) and would soon be coming online. The consultant had heard anecdotal concerns about whether there were a sufficient number of proficient providers interested and available to provide a package of supports needed by individuals in their own apartments; such

providers are essential to meet the needs of the growing independent housing locations. An ample supply of providers is key to addressing the potential for a geographic disparity in the provision of housing and support services.

In October 2017, the consultant found that, with having created 553 housing options, the DBHDS Outcome-Timeline Report shows development almost a year ahead of its projected path to achieve 847 new options by Fiscal Year 2021. The consultant acknowledged that, in past reports (November 2013, 2014), he had been critical of the lack of progress in the actual development of housing options during those review periods; during the past two years, however, DBHDS has made substantial and commendable progress in this area. DBHDS appears well on its way to meeting its projected development targets.

During the June 2017 review, the consultant remained concerned that the ability of the Commonwealth and its providers to align individuals in need of more independent housing options with providers who would have an available and appropriate package of the needed support services, and at the time and geographic location where the LIHTC set-aside units became available. In October 2017, the consultant found that DBHDS currently has a monitoring system, which is capable of tracking the availability of units, which have a DD housing preference, as they come on line. This system makes the units available to members of the Agreement in a timely manner. The 2015 LIHTC allocation has set aside 95 units with a leasing preference for individuals with DD. The 2016 LIHTC allocation has a set aside preference of 53 units. To date, seven individuals in the Agreement's target population have been able to access LIHTC units, which are beginning to become available as the two-year development cycle reaches the point of actual unit production. It should be noted that some individuals in the target population may choose other locations in which to live with the support of a rent subsidy. DBHDS appears to have effectively begun the process to closely monitor the LIHTC development process from unit production to the occupancy of individuals with IDD who will benefit from them.

DBHDS staff have also created a "working draft" of an *Integrated Living Plan (FY 2017 – FY 2019)*. Primary projected long-term outcomes of the plan include a 3% annual increase in the number of providers who support individuals in independent housing statewide. The plan includes several initial activities intended to achieve long-term stated outcomes. As this plan matures, a more detailed baseline measurement tool should be developed to clearly delineate geographic areas and services around the Commonwealth that are struggling with limited available housing and provider capacity problems. The tool will assist in ascertaining the impact that proposed independent housing development activities are having in identified geographic areas with limited resources. Once this aspect of reporting is firmed up, there will be a clearer and more comprehensive picture as to whether the Commonwealth is effectively responding to the identified provider development/geographic service disparity.

The Commonwealth has sustained compliance with *Sections III.D.3., 3a, 3bi-ii,* and 4

The Commonwealth has newly achieved compliance with *Section III.D.2.*

### **8. Regional Support Teams**

The Independent Reviewer's consultant completed a year-long two-phase follow-up review of the Regional Support Team (RST) requirements of the Agreement.

There are several themes in the Settlement Agreement that guide Regional Support Teams:

- Identifying, addressing and resolving barriers and ensuring placement in the most integrated setting;
- Diverting individuals to more integrated settings prior to placements in nursing homes, intermediate care facilities and other larger congregate settings of five or more individuals; and
- Ongoing quality improvements in discharge planning and the development of community-based services.

In order to meet the RST expectations of the Agreement, Community Resource Consultants (CRCs), who staff the RSTs, operate at the micro level of individual situations and then generate insights and actions at the macro level.

The effective functioning of the RSTs depends, at a minimum, on Case Managers submitting referrals to the CRCs and the RSTs with sufficient time to review them prior to an individual being placed in a large congregate setting. Each late referral largely nullifies the purpose of the RSTs for that individual. RSTs report receiving referrals "too late" for between two and five out of every ten referrals throughout Fiscal Year 2017. The RST did not effectively review other referrals due to non-responsiveness by Case Managers/Support Coordinators.

<b>TABLE 4</b>						
<b>Placements Made Before or Concurrent with RST Review</b>						
	<b>SAMPLE CY16</b>	<b>Q4 FY16</b>	<b>Q1 FY17</b>	<b>Q2 FY17</b>	<b>Q3 FY17</b>	<b>Q4 FY17</b>
<b>Late referrals</b>	43%	36%	18%	19%	30%	48%

Although the impact of the RST process continues to be limited by late referrals, when referrals are submitted with sufficient time for barrier identification and resolution, the RSTs are carrying out functions that support the goal of placements in the most integrated setting possible for individuals with HCBS waiver funded services. Overall, when the RSTs have received timely referrals, its process has had positive impacts on the system and on some individual cases. RST members were unanimous in reporting that they consider the RSTs effective at identifying and resolving barriers in some individual cases. For example, during the nine-month period from April to December 2016, seventeen individuals reviewed by RSTs were diverted from placement in large group homes, or other congregate settings, into integrated, smaller settings.

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



have been improved. DBHDS has developed the WaMS System for use in waiver slot management, service plan storage and pre-authorizations. It is important for the RST staff to acquire the technical expertise to take maximum benefit of access to this system. This expertise is critical to early identification of potential placement events that CRCs could plan for and anticipate.

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

Community Resource Consultant (CRC) functioning is still missing the formalized aspects of the “ongoing planning and development of community-based services.” The CRCs continue to perceive this planning and development role as one that exists in their area, but not one for which they have a direct responsibility. CRCs, RSTs and managers in the Provider Development Section at DBHDS all generally perceive that service system gaps and local needs are well known from the CSB level up to the state level. The Commonwealth, however, did not provide documentation that it has identified these gaps. The continuing, and most frequent, reason that larger congregate settings are chosen by individuals and their Authorized Representatives is the absence of more integrated settings that include needed supports and services, especially for individuals with intense medical and behavioral needs, that are in the geographic area of the individual’s family/AR. Only a clear plan for development and needed expansion in services can begin to redress this core problem.

## **9. *Transportation Services***

During the Fall of 2016, the Independent Reviewer’s consultant completed his second evaluation of whether the Commonwealth provides effective transportation services for members of the target population who receive waiver-funded services. The Virginia Department of Medical Assistance (DMAS) administers Non-Emergency Medical Transportation (NEMT), which provides these required transportation services through a brokerage system. The DMAS contracts with Logisticare, a multi-state private sector contractor, to manage the brokerage system. The effective functioning of the DMAS transportation brokerage is critical to achieving the goal of improving the lives of people with intellectual and developmental disabilities and to achieving compliance with the Agreement.

The consultant’s previous evaluation found that DMAS/Logisticare:

- Did not separate out individuals with IDD with waiver slots in its databases;
- Had not completed an analysis related to the delivery of transportation services for these members of the target population; and
- Was not able to undertake the required quality improvement processes without information about the transportation experiences of individuals with IDD waiver slots.

In December of 2015, the Independent Reviewer determined that the Commonwealth was in non-compliance with the transportation requirements of the Agreement. At that time, the Independent Reviewer requested that the Commonwealth develop a plan to address improvements needed “to ensure that its transportation services are of good quality, appropriate, available and accessible to the target population.”

DMAS and Logisticare implemented a number of changes during 2016 and maintained these changes during 2017. DMAS has planned to institutionalize needed improvements to achieve compliance with the Settlement Agreement requirements through an RFP process; it issued a new RFP for Non-Emergency Medical Transportation on November 1, 2016. DMAS expected to award its new contract, including the Agreement's requirements, with a July 1, 2016 start date for transportation broker services that incorporates needed improvements. The Commonwealth recognized that a delay in the award of a new contract would extend the period before the effectiveness of needed changes could be evaluated. Unfortunately, the Commonwealth's original RFP for transportation services was withdrawn and cancelled due to procurement issues. Subsequently, DMAS issued a new RFP on September 25, 2017; it now expects that the new contract will be awarded in December 2017 for implementation on July 1, 2018.

Based on the Commonwealth's revised implementation schedule, the Independent Reviewer projects that an evaluation of the DMAS/contractor quality improvement program for the required transportation services will be possible after a full year of implementation, in the fall of 2019. The Commonwealth projects in its new RFP that transportation for HCBS waiver-funded service recipients, as provided under its contract for non-medical transportation, will transition to managed care organizations beginning July 2019, but no later than July 2020. The Independent Reviewer will plan future independent evaluations to determine whether the DMAS/contractor brokerage system or, if applicable, whether the managed care organizations, has instituted needed improvements and demonstrates:

- The ability to separate out information regarding transportation services for individuals with IDD with waiver-funded services;
- Improved effectiveness of the planned transportation system changes for these individuals; and
- Completion of a full annual cycle of its quality improvement program.

Under its new RFP, DMAS will require the Contractor to adhere to the following terms specific to NEMT services for the IDD populations:

- Separate out IDD Waiver users in data collection and reporting and in the quality improvement processes to ensure that transportation services are being properly implemented for the members of the target population;
- Encourage more users, including IDD Waiver users and/or their representatives, to participate in the Advisory Board process;
- Periodically survey a sample of transportation users to assess satisfaction and to identify problems; and
- Conduct focus groups with the IDD Waiver population in order to identify problems. Until completion of the waiver redesign, the Contractor shall provide NEMT services to waiver services for these members.

During 2017, DMAS reports that it has continued to meet weekly with Logisticare staff to troubleshoot problems. It also reports that Logisticare continues to analyze utilization and complaint trends for the distinct IDD user population, to survey a sample of IDD users who may have satisfaction issues and that Logisticare has implemented some other service and customer survey procedures.

The Commonwealth is in non-compliance with III.C.8.a. It will remain so until it demonstrates an effective quality improvement program for its transportation services for individuals with IDD with HCBS waiver funded services.

## **10. Quality and Risk Management**

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

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

The Independent Reviewer retained two consultants to assess the Commonwealth's progress toward meeting four discrete areas of Quality and Risk Management:

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

Overall, the Commonwealth's Quality and Risk Management initiatives in these four areas are in the process of development and implementation. As a result, the consultants' review of a number of draft documents formed the basis for their report (Appendix I).

### **Risk triggers and thresholds**

The consultants review found that the Commonwealth had not yet "*established or required service providers to risk management processes to establish uniform risk triggers and thresholds, that enable them to adequately identify and address harms and risk of harms.*" The Commonwealth had previously developed draft risk triggers and thresholds, which were largely based on harms that had already occurred. The Commonwealth staff recognized the need for a more proactive approach and one that involves building stronger quality and risk management systems at all levels of the system: state, CSBs, and other service providers. The DBHDS staff drafted the outline of a framework for this new approach, which they recognize requires significantly more work before the framework can be finalized and implemented. Given the size and structure of Virginia's intellectual and developmental disabilities (IDD) system and the need to develop a sustainable risk management system, the Commonwealth's plan to work with CSBs and providers to structure their risk management systems, and then develop mechanisms to ensure those systems are working correctly, is a reasonable one. In the experience of the Independent Reviewer, service providers that build effective quality and risk management systems into their operations generally provide more consistent high-quality services; state service systems ensure high quality services when the service provider agencies are expected to have effective quality and risk management systems in place and the state monitors to ensure that they do.

As the Commonwealth fills in the details of its outlined framework for a quality and risk management system, it should ensure the system has the necessary data and the analysis processes:

- To identify areas of risk and/or harm proactively, as well as retroactively;
- To utilize that data efficiently and effectively to identify the need for interventions; and
- To provide sufficient oversight to ensure that when CSBs or providers need to take action, that they do so and that those actions are effective.

As has been previously reported, the Agreement requires the Commonwealth to implement an effective multi-level quality and risk management system. The Commonwealth's regulations, however, provide significant obstacles to achieving compliance. The existing regulations restrict what the Commonwealth can require of private providers. For example, the regulations do not allow the Commonwealth to require the submission of information, or the attendance of CSB and private provider staff at trainings, needed to implement the risk management and quality improvement system. To achieve compliance, the Commonwealth must address these weaknesses. The consultants' recommendations to improve and strengthen the DBHDS Framework are attached at Appendix I.

The consultants found that the CSBs and private providers interviewed were largely unfamiliar with the concept of risk triggers and thresholds or the Commonwealth's work to develop a risk management framework or system. They were also largely unfamiliar with the resources that DBHDS had posted on its website related to, for example, root cause analysis.

The Commonwealth is charting a new course to address the Agreement's requirements related to tracking of risk triggers and thresholds. This new course will include the involvement of the CSBs and providers and the strengthening of their quality and risk management systems. The DBHDS Quality Management staff recognize that the next phases of DBHDS work to solicit stakeholder feedback and to finalize and then implement the framework, will be substantial; the roll-out of the requirements and related training and monitoring will be keys to its success.

The Commonwealth remains in non-compliance with V.C.1, and, therefore, with V.D.4.

### **Data to assess and improve quality**

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

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

The Commonwealth's Quality Improvement Strategy, which included many of the Agreement's requirements related to quality improvement, is consistent with and not in contradiction to the provisions of the Agreement. Staff report that two HCBS waivers are scheduled for renewal in 2018. The Commonwealth's renewal applications will, reportedly, incorporate a description of numerous changes in the Commonwealth's quality assurance system and will include revised and expanded data measurements. The Commonwealth provided a copy of the most recent draft Quality Management Plan, updated on October 20, 2016. The plan, in its current iteration, presents a comprehensive, high-level description of how the agency structures its Quality Management program. The draft plan has not yet been updated to incorporate some of the more recent modifications made to the way in which DBHDS collects and analyzes data.

The consultants found that both the existing and the draft plans are not the central repository of DBHDS/DMAS efforts to advance the structure and implementation of a data-driven quality improvement system. The plan does not provide a roadmap for DBHDS to expand and improve its ability to collect and analyze data to measure improvement. The consultants recommend that DBHDS consider incorporating a roadmap (e.g., annual plan) as well as this greater level of detail as an attachment to the Quality Management Plan. DBHDS should ensure that the plan is kept up-to-date and reflects its most current plans and initiatives.

The Commonwealth remains in non-compliance with V.D.1.

DBHDS continues to expand and improve its ability to collect and analyze consistent, reliable data to measure:

- The availability and accessibility of services for individuals in the target population; and
- The quality of services offered to individuals receiving services.

To date, DBHDS has focused primarily on identifying measures related to data that are currently available. DBHDS has used a thoughtful approach with a group of subject matter experts to begin evaluation of identified data elements to determine whether the data are accurate and complete and to ascertain how useful these data will be to measure the quality and quantity of services being provided. DBHDS staff recognize that their development of these initial measures was the first step in a much larger project. DBHDS plans for the subject matter experts, working with data analysts, to continue to develop measures, to evaluate the accuracy and completeness of the data and, through analysis, to evaluate further the efficacy and utility of the data measures.

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

Feedback from interviews with staff at four CSBs and five community-based private providers indicated they are not familiar with specific data measures that the Commonwealth is using to measure quantity and quality of services. They are not familiar with the processes DBHDS is developing or considering expanding to improve data reporting and analysis. The Commonwealth continues to be challenged by the absence of a uniform means for reporting key operational data across the provider system. To advance its efforts to establish meaningful data measures of its service delivery system, DBHDS should direct considerable effort. It should clearly define each data element and it should ensure both that each data element can be objectively measured and that an electronic data reporting system exists that will allow providers to consistently and accurately report data, without taking excessive staff time and effort.

The Commonwealth remains in non-compliance with V.D.2.a.-d.

DBHDS produced the “Report on the Eight Domains” in October 2017. The report includes a greatly expanded set of twenty-six data measures with the following number of measures for each Domain:

- Safety and Freedom from Harm – four measures;
- Physical, Mental and Behavioral Health and Well-being – four measures;
- Avoiding Crises – five measures;
- Stability – four measures;
- Choice and Self-determination – two measures;
- Community Inclusion – two measures;
- Access to Services – three measures;
- Provider Capacity – two measures.

The Report on the Eight Domains shows that DBHDS has done solid work in defining relevant measures for each domain, while recognizing some of the limitations of the data currently available. The workgroup took care to develop definitions, as needed, to allow a common and clear understanding of terms. Completing this initial groundwork to expand and refine data measures shows great promise. This is essential to achieving the goal of providing more useful data to assist the Quality Improvement Committee (QIC) and Regional Quality Councils (RQCs) in evaluating services on a broad scale throughout the Commonwealth.

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

The Commonwealth remains in non-compliance with V.D.3.a.-h.

V.D.5. The five RQCs are operational, have the required membership. Each RQC met during each quarter.

The RQCs use a consistent agenda format to guide the structure and discussion of each meeting. Minutes reflect that some discussion items focus specifically on data review. The use of data as the primary focus of discussion in these meetings continues to be in its infancy. An ongoing focus on

structuring the meetings around data analysis presentations will enhance the capabilities of each RQC to identify trends and to recommend responsive actions to address identified issues.

As its use of data continues to evolve, DBHDS should identify data measures/reports that allow comparative presentation of information across Regions and over time. These comparisons will improve the ability of each RQC to provide substantive and meaningful response to DBHDS regarding regional impacts of various new initiatives and process changes that DBHDS implements, or is considering to improve, the service delivery system. DBHDS should consider focusing attention in the RQC meetings on a small number of key measures that lend themselves to comparability and measurement over time. Through this narrower initial focus, the process of data review within the RQC structure can evolve and mature more rapidly.

The Commonwealth remains in non-compliance with V.D.5.

At least annually, the Commonwealth is required to *“report publicly, through new or existing mechanisms, on the availability (including the number of people served in each type of service described in the Agreement) and quality of supports and services in the community and gaps in services, and make recommendations for improvement.”* Although DBHDS established a page on the DBHDS website, and previously posted some information, the documents contained under this tab are not current; do not include an analysis of available data to identify gaps in services; and do not identify recommendations to address identified gaps. DBHDS has stated that, due to upcoming changes to the website, reports previously included on the website have been deleted. After the new website comes on line by January 1, 2018, DBHDS expects to add the annual report information in March 2018.

The Commonwealth is in non-compliance with V.D.6

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

## **Providers**

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

Beginning with Fiscal Years 2015 and 2016, the Commonwealth added quality improvement program requirements to the draft Performance Contract with CSBs.

The Commonwealth's oversight of community providers' quality improvement programs remains a work in progress. The Commonwealth previously surveyed 900 service providers. This survey, which asked foundational questions to establish baselines regarding the status of service providers' quality improvement and risk management practices, provided some insights. The low provider response rate and questions that lacked precision undermined the utility of the survey results. DBHDS reports that it is planning a second survey with more clearly stated questions and with strategies to improve the response rate.

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

The Commonwealth remains in non-compliance with V.E.1. and 2. It has not required providers to implement Quality Improvement Programs or to report its findings from such programs.

## **Quality Service Reviews**

The Independent Reviewer retained two independent consultants to review the adequacy of DBHDS's revised Quality Service Review (QSR) process, the extent to which this process aligns with the Agreement (e.g., to evaluate the “quality of services” and to complete assessments, including via face-to-face interviews with individuals, professional staff, and others involved in the individual's life, and assessments of treatment records, incident/injury data, etc.), and the status of its implementation.

DBHDS completed a review of its QSR Contractor's first year of work and first report. Subsequently, DBHDS decided to focus on realigning some of the contractor's indicators for the key performance areas. DBHDS and QSR Contractor staff worked together to review the driver indicators within the audit tools to link them to these key performance indicators. By August 15, 2017, the QSR contractor had completed all 400 Person-Centered Reviews and fifty Provider Quality Reviews, which focused on providers of day program. A preliminary QSR report was issued on October 16, 2017.



The Independent Reviewer's consultants found that staff expended considerable time, thought, and effort to attempt to address concerns raised previously about the contractor's audit tools and the reports it generated. Although some limited progress was made in defining measurable drivers and the relationship of the measures to DBHDS' key performance areas, it is not evident, overall, that the current QSR process generates valid and reliable results. These problematic results are a consequence of inadequate development of the underlying infrastructure. For example, there was a lack of sufficiently qualified staff and of valid audit tools that are designed to collect reliable information. Another major area of concern is that the audit tools do not offer CSBs or providers a roadmap of what the QSR contractor will assess or the standards by which performance will be evaluated. In addition, the contractor's audit tools do not lend themselves to the production of reports that are concise and that clearly identify findings or specific information about needed actions to make improvements on an individual, provider, and aggregate level.

The problems with the contractor's planned approach, which the Independent Reviewer first described in August 5, 2015, continue to persist. For example:

- Lack of Definition of Standards/Terms – Standards need to be well defined in audit tools to ensure inter-rater reliability, as well as to clearly articulate expectations for providers and CSBs.
- Lack of Definition of Methodology – Similarly, the audit tools do not consistently identify the methodology that auditors would use to answer questions.
- Lack of Criteria for Compliance – auditors continue to use met/not met as the scoring mechanism for many indicators, but the audit tools do not explain how this rating is determined.
- Scope of Review without Definition of Auditor Qualifications The audit tools and resulting reports require staff to make clinical judgments regarding assessments of the adequacy and appropriateness of behavior support plans, nursing care, clinical and medical supports. The audit staff, however, do not have clinical qualifications.
- Missing Components - The audit tools do not comprehensively address services and supports to meet individuals' needs, especially with regard to clinical services. For example, indicators to assess the quality of clinical assessments, as well as service provision, are not evident. This calls into question the validity of the findings.

The consultant's previous report of the QSR process included concerns related to the reliability of the contractor's data, which in part, could be attributed to weak inter-rater reliability. Since the previous review, the contractor made progress in instituting a formal inter-rater reliability process that is more consistent with standard practice. In a document entitled: "Rater Reliability Process Virginia Quality Service Reviews," dated March 10, 2017, the contractor describes informal as well as formal means for ensuring the reliability of the QSR audit data. Based on the consultant's review of its revised inter-rater reliability process, the contractor now has in place a system that should enable it, generally, to confirm the reliability of the data that its audits generate. Based on the summary inter-rater score spreadsheet shared with the consultant, the contractor had identified issues with inter-rater reliability and subsequently completed re-testing.

On October 2016, the contractor issued a preliminary “Virginia Quality Service Reviews Annual Report,” which represented its second annual report. This report clearly reflected an intense amount of work. Like the previous report, in summarizing the results of the PCRs, the newest report made broad statements, such as: “Individuals’ basic needs were consistently met... Over 90 percent of individuals received needed services... Safety needs were mostly met and individuals were free from harm...” Unfortunately, due to the problems identified above with regard to the validity of the tools and the process, the reliability of data collected, and the lack of clinical qualifications of reviewers, it remained unclear whether the findings of the QSR report were accurate.

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

## ***11. Licensing Services and Human Rights***

It is the individual’s Case Manager who ensures that an individual’s essential needs are identified, that service providers are in place, that services are properly implemented and meet the individual’s needs. The residential, day/employment and clinical service providers that implement elements of the individual’s support plan are expected, and are usually licensed to, provide individualized and person-centered services that meet the individual’s needs. The quality of these services will largely determine whether an individual’s ISP goals are met and whether the quality of his or her life is improved.

The DBHDS Office of Licensing Services (OLS) and Office of Human Rights (OHR) are the Commonwealth’s primary systems for regulating the conduct of service provider agencies. The OLS system is also the primary compliance mechanism for Community Service Board (CSB) performance under their contracts with the Commonwealth for the provision of Case Management/Support Coordination services. Consequently, the effective functioning of OLS and OHR in accordance with the requirements of the Settlement Agreement (SA) is critical to improving individuals’ lives and to achieving compliance.

During the tenth and eleventh review periods, the Independent Reviewer retained an independent consultant to complete a year-long two-phase review of that status of the Commonwealth’s compliance with the provisions related to licensing and investigations.

The Independent Reviewer has previously identified, and the Commonwealth has acknowledged, that the DBHDS Licensing Rules and Regulation do not align with the requirements of the Settlement Agreement. DBHDS has continued to draft needed revisions. Its most recent draft (dated July 17, 2017) shows an improved alignment with some of the provisions of the Settlement Agreement, including a clarification of expectations around root cause analysis, risk triggers and thresholds, risk management programs and quality improvement programs. This most recent draft, however, does not include criteria that align with the Agreement’s requirements for enhanced Case Management, Case Manager responsibilities at face-to-face meetings, and an assessment of the

“adequacy of individualized supports and services.” Also, the Case Management checklist used by OLS to operationalize the requirements of the Agreement does not include assessment of the “adequacy of individualized supports and services.” In addition, this checklist is documentation-focused, rather than outcome-focused, and does not include specific probes of the following Case Management requirements: identifying risks to the individual, offering choice among providers (including for Case Management), assembling professionals and non-professionals who provide supports, and amending the ISP when needed.

The first phase of the consultant’s study found that the newly established Regional Manager positions in OLS have been incorporated into the functioning of OLS and into the current version of the OLS *Office Protocol*. Analysis of one randomly selected investigation/corrective action plan suggests that Regional Managers may be relieving enforcement frustrations at the Licensing Specialist level. Following review by the Regional Manager, the Licensing Specialists had looped back to review and cite the Case Managers/Support Coordinator’s handling of challenging cases for which the residential provider may have originally been cited. In both phases of his study, the consultant found an increased frequency of OLS citing CSBs and required corrective actions related to Case Management performance problems.

The consultant’s study found that OLS placed six IDD (intellectual and developmental disability) provider settings on provisional status during Fiscal Year 2017. OLS trend reports suggest that timely reporting (i.e. within 24 hours) of SIRs has remained at about 86-88% during most of 2016. In the consultant’s review of a sample of fifty-five OLS investigations that were closed with a CAP during April 2017, sixteen (29%) providers were cited and required to submit corrective action plans for late reporting (160C.2). OLS data for 2016 also continues to show a significant voluntary closure rate of about twenty (20) agencies/services/settings per quarter. Voluntary closures are frequently a positive byproduct of system oversight in that many marginal agencies will self-select to surrender a license.

As reported previously, OLS appears to have the necessary regulatory tools to force improvements among substandard providers and to eliminate substandard providers who have demonstrated a refusal or inability to improve their services. Interviews with OLS staff confirmed previous findings of a continued systemic reluctance by OLS to pursue use of these other tools, including provisional status, because of the due process burdens on Licensing staff. The occasional use by DBHDS of Service Agreements with problematic providers is potentially a quasi-legal vehicle for leveraging provider improvements, if OLS monitors frequently and strictly during the period of the agreement.

The addition of OLS Regional Managers and an increased number of Licensing Specialists, and changed or additional citations following 45-day reviews, will likely contribute to changes in the patterns and trends. These changes will reflect the increased activity and refocused attention encouraged by the use of new monitoring tools (e.g. *Mortality Review Guidance Document*) by Licensing Specialists. It appears that the OLS Regional Managers have already had a positive qualitative impact on the work of Licensing Specialists.

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

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

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

The Commonwealth's Office of Licensing Services and its Office of Human Rights have improved their oversight mechanisms (i.e., adding Regional Managers, OLS creating its supervisory evaluation tool, OHR implementing a supervisory retrospective look-behind process, OLS implementing the Mortality Review Guidance Document increasing the number of citations for inadequate case management performance, OLS increasing citations of providers for late reporting to DBHDS of serious injuries or deaths.) It is not clear whether any enforcement mechanisms included in the Commonwealth's performance contracts with the CSBs have been utilized to make progress toward fulfilling the requirements of the Agreement.

The DBHDS process of drafting planned revisions to the OLS regulations has continued. The most recent draft (version dated July 17, 2017) includes emphasis on root cause analysis, risk triggers and thresholds, risk management programs, and quality improvement programs. It does not include detailed requirements for Enhanced Case Management, Case Manager/Support Coordinator responsibilities at face-to-face meetings, an assessment of the "adequacy of individualized supports and services," and direct support staff core competencies (these competencies are apparently in the new Waiver regulations). DBHDS is finalizing its new HCBS Waiver Regulations (12VAC30-50-440 to 490) for Case Management/Support Coordination, which show alignment with the Agreement. However, it still appears OLS is the primary monitoring entity for DBHDS regulations.

The Independent Reviewer's studies of Individual Services, Case Management and the DBHDS Licensing and investigation systems have found several problem areas in CSB performance. These areas of continued CSBs' performance problem areas include a lack of offering choice of Case Managers annually, monitoring for risk, ensuring that programs are being properly implemented, assembling, assisting, ensuring that ISPs include all essential needs. In spite of the presence of the Commonwealth's Performance Contract with the CSB, and any enforcement or sanction provisions, CSB performance has not improved substantially, and, as a result, the Commonwealth remains in non-compliance with these provisions.

The Commonwealth is not currently in compliance with III.C.5.d, the requirement to have a mechanism to monitor CSB compliance with Case Management performance standards. DBHDS continues to be in compliance with Section V.G.1. and 2.

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

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

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

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

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

## **12. Mortality Review**

The Independent Reviewer retained an independent consultant to complete a year-long two-phase study to assess the status of the Commonwealth's progress related to the Mortality Review requirements of the Settlement Agreement. The assessment included review of the Commonwealth's planning, development, and implementation of the Mortality Review Committee (MRC) membership, process, documentation, reports, and quality improvement initiatives.

When this consultant reviewed the status of the Commonwealth's compliance with the mortality review provisions during the ninth review period, he identified significant inadequacies. At that time, the records that the Commonwealth maintained related to mortality review lacked information needed for a thorough review; the Mortality Review Committee was categorizing some cases as 'pending', due to lack of information, but not adding information at a later date, or closing the case. The MRC tracking data base had significant gaps and had included conflicting information that did not provide when cases were closed. During 2015 and 2016, the MRC had met an average of twelve or more times each year, but had not met during some months. During 2016 and the first phase of this review, the membership of the MRC included all required members, except one. It did not have a member with the clinical experience to conduct mortality reviews who was independent of the state. During 2015 and 2016, the percent of the mortality reviews completed within 90 days, as required, had declined significantly and, during the first phase of this review in May 2017, the MRC had established an "operating procedure" that resulted in closing cases at 90 days, when it had not yet received sufficient information to complete mortality reviews of clinical value. Although intended to ensure the MRC completed reviews within ninety days, or document the unavailability of needed records, the procedure did not focus on fulfilling the Agreement's requirement. These factors contributed to the conclusion that a "significant percentage of cases closed without adequate information and deliberation" to allow the MRC to "effectively identify problems at the individual" and the "systemic level or the systemic trends and patterns." During the second of the two-phase study, to establish the baseline context for the changes and progress which has occurred, the consultant reviewed and confirmed the current status of:

- The stated purpose and role of the MRC mortality reviews and its role;
- The process for community-based providers' reports of deaths to DBDHDS within 24 hours;
- The clinical review of all information available about the death;
- The presentation of a summary of findings to the Mortality Review Committee;
- The MRC process to categorize each death as expected or unexpected;
- The MRC options for action steps that may occur, machining recommendations; and
- The provision of the outcome of the MRC process (i.e., findings, recommendations. etc.) to the Quality Management Committee and to the Commissioner for review and action.

Details of the consultant's findings, analysis and conclusions are included in Appendix J.

During the second phase of the study, in October, the consultant found that DBHDS had made substantial progress. The MRC had replaced its operating procedure to ensure a focus on "initiating the mortality review within ninety days of the death" and "meetings as often as necessary are reviewed within ninety days with a report prepared and delivered to the Commissioner." The MRC had also instituted a much-improved review process. The MRC now focuses on

- Gathering a standard packet of information in a timely manner;
- Having a nurse reviewer complete a clinical review;
- Summarizing findings following a standard format; and
- Presenting this information to the Mortality Review Committee.

Since the information gathered is now sufficiently complete, when the requested documents are submitted, the new clinical review process has contributed to a trend of the MRC having fewer "pending cases" and timely completion of mortality review with clinical value.

The results of the improved mortality review process are evident in the table below. During the most recent six-month period, the number of cases with "outcome pending" or "outcome blank" has been reduced and the number of cases with "pending resolved" has increased.

<b>Calendar Year</b>	<b># Cases reviewed</b>	<b>Outcome pending</b>	<b>Outcome blank</b>	<b>Pending resolved</b>	<b>Action Steps/Alerts, etc.</b>
2015	307	48	15	31	75
2016	295	9	57	4	80
2017* (Jan-Mar) 3-months	50	2	9	0	23
2017 (Apr-Sep) 6-months	91	8	3	5	52

The MRC process, however, continues to lack a structure or process to rapidly review unexpected deaths. The DBHDS Office of Licensing Services staff are involved in a timely review of such deaths timely, however, Licensing Specialists do not have the clinical expertise to complete a quality mortality review. The MRC has discussed the criteria for Licensing Specialists to use to determine whether medical consultation is needed, “to determine if other individuals in the home may be at risk.” Providing such needed clinical consultation to Licensing Specialist, when needed, could provide a rapid review that ensures the health and safety of housemates; there is no documentation that any action has been taken to implement this recommendation.

During 2017, the MRC has met during at least once every month, as required. Attendance of MRC members has improved during all three quarters of 2017 and minutes of meetings now include the name, expertise and affiliation of each meeting participant.

DBHDS reported that the MRC has not recruited “at least one member with the clinical experience to conduct mortality reviews who is otherwise independent of the State.”

The MRC process for timely completion of the mortality reviews remains a challenge. At the time of the consultant’s interviews with the DBHDS staff, the nurse (LPN) reviewer was completing reviews for the deaths that occurred in April 2017. However, this nurse reviewer had only been in the position for a few months; DBHDS projects that the MRC backlog will be resolved over the next few months. It was unclear if additional nurse reviewer hours need to be assigned, temporarily or permanently, to resolve the backlog of cases needed to meet compliance in this area.

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

Previous reviews found significant gaps in the MRC data base, “Mortality Tracker.” Many columns were blank, data indicated that documents that were the custody of the Commonwealth were reported as not available, and it was not clear whether “no maltreatment” meant that records were not available or that no maltreatment had occurred. The second phase of this study found significant improvement. DBHDS data analysts have created systems to review the data for completeness, accuracy, and consistency. To improve the completeness and integrity of the data available, it has limited the number of staff with privileges to enter/edit data to improve consistency, streamlined the review process, and added a layer of review to check data reliability. The need for definitions for each data field, however, remains unaddressed and a challenge. DBHDS limited the number of staff with privileges to enter/edit data to improve consistency, streamlined the review process, and added a layer of review to check data reliability. The need for definitions for each data field, however, remains unaddressed and a challenge.

The MRC is continuing to make further improvements in data collection. Currently DBHDS is working toward capturing death certificate information electronically. The table below depicts the improvement as of October 2017 in the information available for the mortality reviews.

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

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

The MRC has also established a process for tracking follow-up to its recommendations using its “Follow up Action Documentation and Reporting Process.” This process includes specific tracking of each recommendation. This tracking includes identification of the lead office assigned to each recommendation, the completion date and any actions taken.

The MRC has significantly improved its process, which has positively impacted the quality and completeness of required documentation and data integrity and the quality of the MRC reviews. These improvements have allowed the MRC to discuss and determine findings more effectively and efficiently, to improve the accuracy of its categorization of each death and to make needed recommendations. The MRC has been able to significantly increase its ability to obtain and to review the needed documents given the increased staff support that DBHDS has provided to the MRC. The current MRC processes appear to be a much more effective and efficient process and to be improving the quality of the mortality review process and outcomes.

### **Annual Report of Mortality**

DBHDS finalized and published the annual report Mortality Among Individuals with a Developmental Disability: DBHDS Annual Mortality Report for January 1, 2015 – June 30, 2016.” This “Annual Report” included an eighteen-month period, so that the time period of future annual reports would align with the twelve months of the Commonwealth’s Fiscal Year. The most recent report includes a review of available MRC data, analysis and a summary of findings. The Report also included several recommendations that were based on MRC findings and which provide direction for future endeavors by the MRC.

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



## **Quality Improvement Program**

The MRC completed the “Mortality Review Committee Quality Improvement Plan March 2017,” prior to the first phase of the consultant’s study. The Improvement Plan listed eight goals that were based on the recommendations included in its “Annual Report.” Each goal had from one to eight action steps to be completed in order to achieve the goal. The plan identified the office responsible for implementing each action and the date when it was expected to be completed. At that time, two of the action steps for one of the goals had been completed. The MRC provided and updated its document, “Mortality Review Committee: Quality Improvement Plan Calendar Year.” At the end of the eleventh review period, September 30, 2017, DBHDS reported progress and the completion dates for one or more action steps toward achieving each of three of the goals. No progress was reported on the implementation of the action steps listed for the other five goals.

The DBHDS Quality Improvement Committee reviews the MRC recommendations every six-months. At its July 6, 2017 meeting, an update was provided to the QIC on the progress that the MRC has made and its recommendations. The QIC did not identify any actions that it would take or recommend based on the information provided.

## **Offer Guidance and Training to Providers**

The Office of Integrated Health Services (OIHS) also provided ongoing technical assistance to the community service providers. The MRC makes recommendations that OIHS follow-up on issues identified in mortality reviews, including developing safety alerts and providing training and/or technical assistance. OIHS was in the process of finalizing, and/or updating, several Alerts, since phase I of this review in May 2017. The consultant reported that the alerts were of high quality. They were written for easy understanding by the lay public and included source references. OIHS had also created one page, “in a nutshell,” summaries of these alerts. These revised Alerts are an indication of an ongoing quality improvement approach: the periodic review of what has been learned since the implementation of a policy and practice that addresses a complex issue, whether it had achieved the intended outcome, and whether it can be improved, and, if so to identify and make needed revisions. It is important that OIHS recognizes that its safety Alerts should be periodically updated (e.g. every 2 to 3 years).

## **Collecting and Analyzing Mortality Data**

MRC has significantly improved its processes for collecting and for documenting data. The second phase of this review found positive result from the work of DBHDS staff in this area. The MRC’s Mortality Tracker data base includes additional categories and is more complete. This progress is due, in part, to access to autopsies, death certificates, and improved documentation, as well as to the MRC reliably entering the information that it has received. Having more complete information will allow DBHDS to more effectively identify trends, patterns, and problems at the individual service-delivery and systemic levels and develop and implement quality improvement initiatives.

The Commonwealth is not in compliance with Section V.C.5. The MRC has made important and positive progress. It has improved its processes for gathering needed documents, for collecting data, for documenting the records of its deliberations, findings, and recommendations; it has begun elements of a quality improvement program to reduce mortality rates. The MRC membership does not meet the requirements of the Agreement.

### **13. Provider Training**

The Settlement Agreement provides specific direction to the Commonwealth regarding the provision of core competency-based training for all staff who provide services under the Agreement. It states:

*“V.H.1. The Commonwealth shall have a statewide core competency-based training curriculum for all staff who provide services under this Agreement. The training shall include person-centered practices, community integration and self-determination awareness, and required elements of service training.*

*V.H.2. The statewide training program includes adequate coaching and supervision of staff trainees. Coaches and supervisors must have demonstrated competency in providing the service they are coaching and supervising.”*

In the Fall of 2014, 2015, and again in 2017, the Independent Reviewer retained an independent consultant to review the status of the Agreement’s requirements related to competency based training. Between May and November 2017, two consultants completed a two-phase study that included extensive review of documentation and interviews with senior staff at DBHDS, four CSBs, and five private community-based IDD service providers. The CSBs and private providers that were included in the study were selected by the Independent Reviewer.

DBHDS began implementing its Provider Training Plan in December 2015. DBHDS updates list the six strategies and updates on completion of major milestones and tasks. A brief description of the DBHDS strategies and status reports for each, the areas of focus for the interviews at DBHDS, CSBs and service providers, are included at Appendix K.

Overall, DBHDS, through an organized planning and implementation effort, has taken some important steps in the development and implementation of a statewide core competency-based curriculum for staff who provide direct services and supports for individuals in its various programs for persons with intellectual and developmental disabilities.

DBHDS leadership staff have begun to evolve the role of DBHDS from one of provider training to “provider development.” Specific to training initiatives, *DBHDS plans to establish expectations*, and develop or coordinate the development of some curricula. CSBs and providers *are expected to develop* additional curricula as needed, and provide or purchase training. This shift in responsibility will redirect human resources within DBHDS from the role from providing direct training to supporting the development of each provider’s staff training capacity. This shift appears necessary as the system of community-based services grows larger and more complex across the Commonwealth. In the experience of the Independent Reviewer, the best providers have dependable systems in place that ensure that each staff can demonstrate competence when proving the elements of each individual’s services. The service system should include oversight mechanisms (i.e., case management, licensing, post move monitoring, investigations) that ensure that each service provider has such competency-based staff training systems in place.

DBHDS established mechanisms to obtain input from and participation of providers and other relevant stakeholders in developing the Provider Training Plan, the training curriculum, and the training manual. DBHDS also implemented a communication plan to provide information to its

network of impacted community-based providers and CSBs about the training plan, the providers' responsibilities to ensure effective use of the revised training curricula, for both new and incumbent staff, and the requirements for providers to measure competency of staff initially and on an ongoing basis. DBHDS reports devoting considerable effort to share information with provider organizations through its ListServe. Consultant interviews found that providers and CSB staff were aware of this information source and, as the revised core competency-based training processes have evolved, they shared increasing references to and familiarity with the information promulgated by the Department through this information source.

DBHDS developed an orientation training curricula and competency-based measures for direct support professionals and their supervisors, which represented significant revisions to the previous orientation training manual. DBHDS began initial implementation of this revised curricula and checklists in the fall 2016; and it expected all service providers to train or retrain all staff by February 28, 2017. DBHDS continued to review and revise these curricula and, on September 25, 2017, issued revised curricula for behavioral and autism competencies for Direct Support Professionals and Supervisors.

The Commonwealth made emergency modifications to regulatory requirements to establish an initial mechanism for review and enforcement, if necessary, of providers' adherence to the training requirements. Emergency regulations (i.e., 12VAC30-120-515) related to the Waiver implementation, which are in effect from September 1, 2016 through February 28, 2018, set forth the requirements for competency-based training. DBHDS staff anticipate that final regulations will be approved in advance of the February 28, 2018 expiration date of the emergency regulations.

The Commonwealth has continued to review, improve and expand its provider and Case Manager training curricula. It has streamlined two sets of competencies, updated the Supervisors' training requirements, and is revising the Case Manager training modules. DBHDS provided training for Case Managers on August 30, 2017 and the Office of Integrated Health Services continued to provide training related to significant health issues and dental services.

As the full implementation of the revised training competencies and supervisory coaching matures, DBHDS has not yet, but must, develop mechanisms for determining whether CSBs and providers are implementing the competency-based training, whether the training results in staff being able to demonstrate competence, and whether the competencies developed are having the intended impact in more positive and fewer negative outcomes for the individuals served.

DBHDS reported considering utilizing its Office of Licensing Services, which provides regulatory oversight of community-based providers, as the primary means to measure compliance with the newly revised competency-based training requirements for staff. DBHDS has not yet established the indicators of compliance or what measures Licensing Specialists would utilize to determine the extent to which a provider has adhered to the indicators that training requirements had been met and, if not, how it would remediate any issues identified. The DBHDS Quality and Risk Management Division staff recognize the need to incorporate training and the outcomes of training into the measures they are developing.

The DBHDS Quality and Risk Management Division staff recognize the need to incorporate training and the outcomes of training into the provider training measures they are developing.

The Commonwealth staff have made progress in developing and disseminating a set of competencies designed to improve the quality of services and supports provided to individuals with IDD that the system services. However, after completing their recent review, the consultants reported several concerns:

- Many of the competencies that the Commonwealth has developed are not measurable. This lack of measurability is a serious flaw. If not addressed, it will negatively impact both providers' ability to consistently ensure their staff have the necessary competencies and the Commonwealth's ability to reliably measure providers' compliance with, and otherwise hold providers accountable to fulfill, the requirements.
- The Commonwealth has not identified or created the mechanisms, or the responsibility, to develop additional competencies necessary for staff to fully support individuals with complex medical and behavioral needs.
- The consultants were not able to determine whether supervisors had actually assessed whether staff could demonstrate competencies after the staff had "completed" the new competency-based trainings. All staff were required to complete by February 28, 2017. The consultants' study was also too limited to make definitive findings about providers' ability to assess and modify their staff training curricula and delivery mechanisms to ensure that all staff can demonstrate competence.

DBHDS has taken a number of important steps to develop and to begin implementation of a reasonable plan to ensure the competency of all staff who provide services for individuals under the terms of the Settlement Agreement. The Commonwealth developed the plan with input from stakeholders and established milestones to measure the completion of required elements. The plan contains methods to ensure effective communication of plan requirements, implementation efforts, and, to a limited extent, resources available to service providers to deliver effective competency-based training. DBHDS's implementation has continued to demonstrate that its staff have become aware of necessary additions and/or improvements, and has made some of these revisions as its implementation has progressed. However, DBHDS has not yet implemented mechanisms to fully measure CSBs' and providers' implementation of the training requirements.

The Commonwealth has not identified a set of measurement criteria, data indicators to measure the quality or impact of the revised competency-based training, or specific positive or negative outcomes that will be measured to determine the efficacy of the competency-based training plan. The Commonwealth has not yet finalized how the Office of Licensing Services, DMAS, and the DBHDS Quality and Risk Management Division will assess various components of CSB and provider training. While the monitoring portion of the plan is being finalized, the Commonwealth must develop specific data indicators and measurement criteria. Training requirements and identified competencies that cannot be consistently measured cannot be effectively implemented, or monitored or result in reliable reporting. This review did not assess the quality of the training provided and/or the outcome of the training in terms of the competency of staff.

#### **IV. CONCLUSION**

During the tenth and eleventh review periods, the Commonwealth made a concerted, statewide and multisystem effort to implement its redesigned HCBS waiver programs. Although not expected to immediately impact many aspects of service provision, the redesigned waivers have resulted in substantial change in the provision of integrated day services. Individuals and families have shown significant increased interest and providers have demonstrated the ability to implement this new model. The Commonwealth will continue to implement the redesigned waivers and will incorporate other planned changes in its two waiver renewal applications in 2018. Planned changes include new services to support the provision of the new integrated day services and additional quality strategies to strengthen its quality management system as required by the Agreement.

The Commonwealth's previous initiatives to create more integrated housing options have resulted in a significant increase in the availability of independent living options and smaller more integrated group home serving four or fewer individuals. The Commonwealth has made substantial progress in other areas as well: medical care, Office of Licensing Services and Human Rights oversight, ground work for a quality management system, diversion of children from admissions to Nursing Homes, and timely responses by mobile crisis teams. XXX The Commonwealth is currently in non-compliance with many provisions due to or more of the following factors: the lack of planning, development, implementation, effectiveness or adequacy. Six core areas of concern that the Independent Reviewer will prioritize these areas for monitoring and review during the twelfth and thirteenth review periods:

- CSB Case Management and the Commonwealth performance contract
- Crisis Services, ongoing behavior support services, and psychiatric hospitalizations
- Pay rates for in-home nursing and direct support professionals
- Children living in nursing homes and ICFs
- DBHDS Licensing Regulations and Quality and Risk Management and Quality Improvement Programs at the provider and CSB levels.
- Provider training and staff competency in the elements of each individual's services

The Commonwealth's leaders are pleased with the progress and accomplishments that it has achieved during the first year of implementing the redesigned HCBS waivers. The Commonwealth has initiatives underway, or under consideration, to address most of the six core areas of concern listed above. As systemic changes will continue during the coming year and beyond, it is critical that the Commonwealth revise its Licensing regulations as soon as possible and inform the CSBs and providers of its requirement that they implement quality and risk management and quality improvement programs. Effectively implementing these programs, as required by the Agreement, will provide important safeguards as the Commonwealth implements system change efforts that will fulfill the requirements of the Agreement and its promises to all Virginians, especially those with intellectual and developmental disabilities and their families.

## **V. RECOMMENDATIONS**

The Independent Reviewer's recommendations to the Commonwealth regarding services for individuals in the target population are listed below. The Independent Reviewer requests a report regarding the Commonwealth's actions to address these recommendations and the status of implementation by March 31, 2018. The Commonwealth should also consider the recommendations and suggestions included in the consultants' reports included in the Appendices. The Independent Reviewer will study the implementation and impact of these recommendations during the thirteenth review period (April 1, 2018 –September 30, 2018).

### **Behavioral Support Services Recommendations:**

1. The Commonwealth should establish basic expectations for the adequacy of behavioral programming. The Commonwealth's expectations should address the following issues:
  - developing, training, and monitoring by a qualified professional,
  - completing a comprehensive functional behavioral assessment in the current setting,
  - including key components in a behavior support plan,
  - including clear specification of measurement procedures regarding data collection,
  - ongoing data collection on target and replacement behaviors, and
  - including evidence based strategies
  
2. The Commonwealth should establish basic expectations for the adequacy of Behavior Support Plans. The Commonwealth's expectations should address the following issues:
  - developing, training, and monitoring by a qualified professional;
  - individualizing (e.g., based on the individual's needs as well as skills, preferences, etc.);
  - emphasizing positive behavior interventions and supports;
  - targeting behaviors for decrease, using observable and measurable terms;
  - targeting behaviors for increase, including functionally equivalent replacement behaviors;
  - measuring and reviewing procedures for data collected on target and replacement behaviors
  - modifying the environment to prevent or lessen the likelihood of target behaviors and to support adaptive behavior.
  - identifying antecedents (or 'triggers') and the provision of related preventative strategies,
  - teaching strategies aimed at teaching and/or eliciting adaptive behavior.

### **Case Management**

3. The Commonwealth should provide additional support and technical assistance to CSBs that do not meet DBHDS Data Dashboard targets over time. The Commonwealth should require quality improvement plans for CSBs that achieve less than the DBHDS targets, as follows:
  - require a quality improvement plan, including a “data entry improvement plan”, for CSBs that achieve less than 80% on all Data Dashboard measures.
  - require a “Case Management/Support Coordination” performance improvement plan for CSBs that achieve less than 90% on all Data Dashboard measures.
4. DBHDS should require documentation of the Case Manager’s annually required to “offer of choice among providers, including of case managers”, as it has with the annual requirement to provide education of less restrictive services. The annual ISP process would include a meaningful discussion of choice. The ISP document would include a standard offer of choice of service providers, which would be reviewed and signed, if approved, by the individual/Authorized Representative.

### **Office of Licensing Services**

5. The Commonwealth should complete and publish needed revisions to its Licensing Regulations. The revised regulations should align with all related requirements of the Agreement and ensure that the Commonwealth can and does take appropriate actions, as needed.
6. The Office of Licensing Services should modify its Individual Served Record Review Form checklist to specifically include: probes identifying risks to the individual, offering choice among providers, assembling professionals and non-professionals who provide supports, amending the ISP when needed, and determining the adequacy of individual supports and services.

### **Training**

7. The Commonwealth should review and confirm that all competencies are measurable that are developed for the competency-based training curricula.
8. DBHDS should implement look-behind protocols to ensure that “successful completion” of any competency-based training requires staff to demonstrate the trained competencies.

### **Regional Support Teams**

9. DBHDS should revise its approach to RST review of true emergency placements (i.e. those that could not have been anticipated and threaten the individual's well-being if not addressed immediately). Placements that are considered true "emergencies" should not be delayed to process a referral to the RST. These emergency placements, however, should be sorted differently and be distinguishable in the data analytics for RST.

### **Supported Employment**

10. The Commonwealth should study the recent decline in the number of individuals with Wavier-funded supported employment services; and it should identify and address the barriers to achieving its employment targets.

### **Crisis Services**

11. The Commonwealth should study and determine the root causes of the significant increase in admissions of individuals with IDD to state operated psychiatric facilities. Studies found two related factors: an unexpected high rate of families refusing REACH services and not all CSB ES Teams informed REACH of individuals with IDD being screened for psychiatric admission.

### **Quality and Risk Management**

12. DBHDS should create a comprehensive data quality improvement plan that provides a roadmap and specific milestones. This plan should guide its ongoing efforts to expand and improve the quantity and quality of data collected, and the Department's effective use of data in its measurement of performance.