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

March 6, 2012 – October 6, 2012

Respectfully Submitted By:

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Independent Reviewer
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I. EXECUTIVE SUMMARY

This is the first report to the Court in the Settlement Agreement (the Agreement) between the United States and the Commonwealth of Virginia (the Parties), Civil Action No. 3:12cv059, which appointed the Independent Reviewer (the Reviewer). This report covers the period March 6, 2012-October 6, 2012, although information is included that was gathered through November 30, 2012.

The Agreement states the Commonwealth of Virginia's (the Commonwealth) intention to provide services in the most integrated setting appropriate to the individual needs of those with intellectual and developmental disabilities (ID/DD) who receive services in accordance with their informed choice. The Agreement includes a commitment to reform the Commonwealth's service system for individuals with ID/DD with the explicit aim to achieve the goals of community integration, self-determination, and quality services. These goals have paramount importance for Virginians with ID/DD. When the Agreement is fully implemented, and compliance is achieved, at least an additional 4170 individuals will be supported with integrated residential and day services in the community. This includes at least 805 individuals who currently reside in the five Training Centers, and 180 children who reside in nursing facilities and large community Intermediate Care Facilities (ICF). Also, 1000 individuals who live independently, or with their families, will receive support services.

Successful implementation of the Agreement's requirements will also provide: enhanced individualized service planning, coordination, monitoring, and safety. It will ensure increased information about and choices from a broad array of more integrated services; including community living, integrated day, and supported employment options. The Commonwealth will give timely and accessible support for all individuals with ID/DD who experience crises to stabilize without inpatient services. The quality of services in a reformed service system will be supported by increased and statewide performance standards in several important areas including staff training, oversight and guidance, program monitoring, risk management, and quality assurance processes.

These increased community-based services and systems reforms are critical to the lives of thousands of individuals and families and to the inclusiveness, vitality and diversity of communities throughout the Commonwealth. Families of individuals, and the self-advocates; those who receive services, those waiting, and those with significant needs but not eligible; describe the responses they have experienced from the service system as inadequate and often overwhelming. These families are often already overwhelmed by the challenges of raising family members with complex needs. Some of the families of Training Center residents are concerned for the well being of their loved ones who will move to new homes. Some of the families waiting for services share the worry that the promises in the Agreement will not be realized.

Today, there are many Virginians with ID/DD who have benefited from services that have helped them create opportunities, build relationships and improve their lives. These include residential services that have supported their personal skill development to become more self-sufficient and to live with greater independence. Employment programs have promoted skill development and opportunities to discover the capacity and satisfaction of meaningful work, earned income, and becoming a taxpayer. Individuals with the most complex needs can be, and are, supported in integrated settings that help people discover opportunities for meaningful participation in their communities. While these service options and positive outcomes exist for some individuals, they are not yet readily available on a sufficient scale, or with the timeliness, that allows for a full realization of their benefits. That is the essential challenge faced by the Commonwealth.

There are many people who are now working together to make needed changes. The Commonwealth's Governor, General Assembly, Offices of the Secretary of Health and Human Resources and the Attorney General, The Commissioner of the Department of Behavioral Health and Developmental Services (DBHDS) and his Senior Staff, Community Service Boards (CSB), private providers, parents groups, and other Commonwealth agencies, stakeholders, advocates and community partners have all made vital contributions to the early efforts to implement the Agreement. Stakeholder involvement is fundamental for successful implementation and sustainability of reforms.

The Reviewer is pleased to report that the Commonwealth has demonstrated a good faith effort to comply with the Agreement's requirements that have been monitored. Considerable progress has been made. Most accomplishments to date have occurred with programs prioritized for early planning, funding and implementation. The Governor requested, and the General Assembly appropriated, $30 million to the DBHDS Trust Fund in FY11, and after reaching the Agreement increased that to $60 million. DBHDS used some of these funds to organize and implement statewide initiatives that are service system cornerstones upon which the success of the other Agreement initiatives depend. Planning has begun on eighteen projects, each with a leader and team, several of which include stakeholder members.

The Reviewer has prioritized six areas of primary importance and with due dates for the first review period, March 6, 2012 - October 6, 2012. They are: Waivers, Case Management, Crisis Services, Integrated Day Activities and Employment First, Discharge Planning and Transition from Training Centers, and the safety of those living in the community. The Reviewer also monitored the planning and initial development activities for other provisions that are vital to individuals and families and to achieving the goals of the agreement. More extensive monitoring will occur during the second reporting period, October 7, 2012 - April 6, 2013, as these programs are developed further and as more and complete data are available. These provisions include Waiver slot placements from the wait lists, Individual and Family Support Program, Access and Availability of services, Community Living Options, Community Resource Consultants and Regional Support Teams, and Quality and Risk Management.

Waivers: The Commonwealth met the requirement for FY12 and FY13 to establish Home and Community Based Services (HCBS) Waivers for 895 individuals with ID/DD to allow residents of the Training Centers, and nursing facilities and large community ICFs, to move to community settings and to prevent the unnecessary institutionalization of individuals living in the community. In FY 13 this provision targets forty waiver slots for individuals under twenty-two years of age to transition to the community from nursing homes and the largest ICFs. Twenty-five slots are for individuals with ID and fifteen for with DD, other than ID. DBHDS is working with the Department of Medical Assistance Services (DMAS) and the Centers for Independent Living to determine the individuals who would choose to transition during the latter part of FY13. Although the Commonwealth established the number of required waiver slots, it is the Reviewer's preliminary opinion that the ID wavier rates and structure create incentives that promote congregation and are inadequate to serve those with the most complex needs.

A **Case Management** core competency-based training curriculum has been developed and completed by 2,750 staff. This has been a significant investment and step forward in establishing a statewide standard of care for case management services. Statewide performance standards are required by the Agreement. Currently, the case management services provided by 40 different CSBs, and by non-CSB case managers, are characterized, in part, by their different operating procedures, forms and training. Case managers will fill an expanded and more vital coordination and

accountability role in the future. Significant improvements are necessary to accomplish both the Agreement's required performance standards for case management, and the long-term goals of the Agreement. These performance standards apply to both ID and DD case management. The Reviewer has not yet had time to analyze the quality of the core competency-based training or the extent to which DD case managers have been trained.

Crisis Services have been initiated utilizing a statewide, tested and reliable service model. Due to the early start, the crisis services implementation plan did not include the Agreement's requirements to serve adults with DD or children with either ID or DD. The Commissioner clarified that crisis services must be available to adults with DD. Questions remain about their access to case management and, therefore, other services. Development of the crisis services has been delayed for typical reasons (i.e. slow hiring of staff and preparation of buildings) and to accommodate less than expected funding. Progress toward full compliance requires adequate resources to implement a plan to provide crisis services for children. In addition, it requires that adults with DD have full access to crisis services. Finally, the Commonwealth must ensure that the crisis services program operations in all five regions and existing emergency services work together to meet the Agreement's statewide performance standards.

Integrated Day Activities and Employment First will be the priority service options to create opportunities for individuals served to become valued participants in their communities. The Commonwealth was a leader in this field twenty years ago, but fell far behind due to the way day services have been funded. To implement the Agreement, an employment coordinator was hired, trainings provided, and an Employment First policy and a Strategic Plan were developed. The policy includes the elements required by the Agreement. However, it is the Reviewer's assessment that although the Strategic Plan requires significant further development and specificity to comply with the required implementation plan. The Strategic Plan did include the collection of some data, but did not establish the required meaningful targets for improvement. Although the data collected is limited, it is the Reviewer's assessment that they are adequate to establish initial, yet meaningful, targets to increase integrated day activities and supported employment. DBHDS expects to establish the targets by March 31, 2013. Involvement of the SELN in developing the specifics of the implementation plan and the targets is important for an effective plan and to comply with its required consultation role.

Discharge Planning and Transition from Training Centers has made impressive progress. New discharge and post-move monitoring processes were implemented on time at all the Training Centers from which 117 individuals have moved to community homes. An Individual Review study of those who moved in FY12, before new processes were required, established baselines for needed progress. Strengths of the former process were noted, as were areas of concern. Several Improvements have since been implemented. The individuals who transitioned during FY 12 and their Authorized Representatives were willing to consider moving to the community, and there was capacity to support them. Although they have substantial needs, as a group they did not represent those with the most complex needs living in the Training Centers. The Reviewer has not had time to thoroughly study the reasons that the individuals with the most complex needs did not move in FY12. However, from preliminary analysis, it is the Reviewer's initial opinion that three factors may have contributed. These include the lack of information provided to individuals and families about available community-based service options, especially by families of individuals with similar needs who were already receiving such services. A second issue is the lack of the Regional Support Teams to assist in resolving identified barriers to moving to the most integrated setting. A third factor is the inadequacy of the existing waiver funding rates and rate structure. This inadequacy has resulted in limited provider capacity to serve those with the most complex needs. Initial steps have been taken and the Commonwealth expects to begin the family-to-family mentoring program in December 2012 and the Regional Support Teams in

January 2013. DBHDS reports that discussions are underway to determine the best method for learning how to restructure the waivers and rates to achieve the desired results.

The safety of the individuals in the community was monitored in three ways: an Individual Review study was completed; reports of Serious Injury and Deaths (there have been no deaths) were reviewed; and the tracking process established by DBHDS for serious injuries and deaths was studied. The Reviewer and expert consultants met face-to-face with fifty-two of the fifty-nine individuals who moved from the Training Centers to the community in FY12. The Discharge Planning - Individual Review study was completed for thirty-two individuals randomly selected to provide a sufficient degree of confidence that findings can be generalized to the fifty-nine individuals. For all the individuals who moved, the reports of serious injuries were reviewed. The Reviewer completed reviews of four individuals who have experienced events that resulted in injuries that required on-going medical care. These events included falls, aspirations, and self-injurious behaviors. In each situation the DBHDS licensing specialists followed established procedures of investigating the injuries, completing unannounced visits, interviewing relevant staff, reviewing records, and if needed, developing Corrective Action Plans. Reports of these reviews were filed under seal to the Court with copies to the Parties and Intervener counsel. Then they monitored implementation of recommendations. DBHDS has established a project team to address new licensure, human rights, risk management, and data analysis requirements.

Other monitoring activities included the Reviewer, and expert consultants, meeting with individuals served, family members, staff and government officials. They also gathered information from a broad array of sources, including visits to more than sixty sites to observe, interview, review documents, and study records. He has had regular, formal and informal communication and meetings with the Parties and with stakeholders. All have graciously responded to requests for information and to share their perspectives. The Reviewer will report to the Court twice yearly for the pendency of the Agreement.

The Reviewer has also monitored, though with less and varying levels of intensity, the initial planning and development activities of other major topics of the Agreement. These topics include individual and family supports, integrated housing, placements off the wait lists discharge from training centers other than SVTC and CVTC, "barrier-busting" mechanisms, and family-to-family and peer programs.

Included in this report are: brief descriptions of the activities of the Commonwealth and the Reviewer, findings for major initial initiatives, next steps required for progress toward compliance, additional information and financial considerations, conclusion and recommendations.

During the second review period, October 7, 2012 - April 6, 2013, the Reviewer's more intense monitoring will focus on the general areas of placements from the wait lists, individuals with DD under 22 years of age living in nursing homes and larger ICFs, integration, safety, and services to avoid unnecessary institutionalization. The specific provisions include completion of the Integrated Day Activities and Employment First implementation plan. They also include implementation of the Integrated Day Activities and Employment First policy. In addition, the specific provisions include the development of Community Living Options to provide independent housing; full implementation of the Community Resource Consultant, Community Integration Manager, and Regional Support Team initiatives; Quality and Risk Management; development of the Individual and Family Support program; and meeting the performance standards for Crisis Services.

II. INTRODUCTION

This is the first report to the Court in the Settlement Agreement (the Agreement) between the United States and the Commonwealth of Virginia Civil Action No. 3:12cv059, which appointed the Reviewer.

In the Agreement, the Parties committed to improve the lives of people with ID/DD by preventing their unnecessary institutionalization and by providing opportunities to live in the most integrated settings appropriate to the individuals' needs consistent with their informed choice, and by reforming the service system. It is the explicit aim of the Agreement to achieve the goals of community integration, self-determination, and quality services.

These goals have paramount importance for Virginians with ID/DD. Fulfilling them will allow these individuals to live and participate as valued members of their communities, families and networks of friends. When fully implemented and compliance is achieved, the Agreement will result in the addition of at least 4,170 individuals in the target population being served in the community. There are 805 waiver slots targeted for individuals currently residing in Training Centers, and twenty-five ID and fifteen DD waiver slots in fiscal years (FY) 2013, 2014, 2015, and 2016 targeted for individuals under twenty-two years of age to transition from nursing facilities or community based Intermediate Care Facilities (ICF) to more integrated settings. For those most at risk of institutionalization and not receiving waiver-funded services, 700 in FY13, and 1,000 individuals annually thereafter, will receive individual and family support services.

Successful implementation of the Agreement's requirements will also provide:

- enhanced individualized service planning, coordination, monitoring, and safety;
- increased information about, and choice of, an array of more integrated services including community living, integrated day, and supported employment options; and
- timely and accessible support for those who experience crises to stabilize without inpatient services.

The quality of services in a reformed service system will be supported by increased and statewide performance standards in several important areas including staff training, oversight and guidance, program monitoring, risk management, and quality assurance processes. In brief, effective implementation of the Agreement's provisions is envisioned by the parties as providing opportunities for improved lives for these Virginians and a reformed service system that continues to provide positive outcomes for the sustainable future.

These positive outcomes are more than aspirations for individuals and families. They are critical to their lives. As of November 2012, there are more than 6,200 individuals on the ID wait lists and 1,167 on the DD wait list in the Commonwealth. Families of individuals who receive services, those waiting, and those deemed ineligible, describe the response they have experienced as inadequate and often overwhelming. They are often already overwhelmed by the challenges of raising family members with complex needs. They characterize the inadequacies as existing in every sphere:

- the very high level of need to be eligible for any waiver funded services;
- the complicated and overwhelming bifurcated service system with multiple waivers;
- the lack of clear and responsible points of access to available services;
- the challenges of two agencies responsible for the ID and DD services, especially for families with children who are DD and uncertain about an ID diagnosis;
- the lack of available services and low payment rates to support individuals, especially for those with the most complex needs;
- the lack of timely, accessible and knowledgeable assistance in crises and the threat of institutionalization when involved with local police or hospitals unfamiliar with the service system;
- the limited array of service options that offer truly integrated services; and
- the disparate quality and availability of services in different locations and among providers.

To reform the service system and address some of the shortcomings that stakeholders have experienced, the Commonwealth has taken impressive steps before and throughout the first reporting period. Still progress is very slow from the perspectives of most advocates. Continuing to effectively implement a coordinated and comprehensive plan that includes the provisions of the Agreement is essential for success, for compliance, and for addressing the challenges that are critical to the lives of individuals with ID/DD and their families.

III. ACTIVITIES OF THE COMMONWEALTH

The Commonwealth initiated a concerted effort to plan, fund, and initiate the early priority program initiatives before the Parties finalized or signed the Agreement. These priorities – waiver slots, case management, crisis services, integrated day activities and employment support, discharge planning and transition from Training Centers, and safety – are cornerstone elements of an effective statewide service system and have due dates during the first review period. The early efforts of the Commonwealth were critical to the considerable progress that has been made. These efforts included planning, funding and providing leadership.

Since the Parties signed the Agreement on January 26, 2012, the Commonwealth has demonstrated good faith in complying with its requirements for the first reporting period that the Reviewer has monitored. They have also begun the important planning activities to meet future Agreement obligations. The Governor has provided important leadership. The General Assembly has appropriated needed funding. Senior staff of the Virginia Office of the Secretary of Health and Human Resources (VSHHR), and from many other Virginia state agencies, have participated in implementation workgroups. The DBHDS Commissioner and Senior Staff have planned, organized resources, and provided leadership to a broad range of initiatives. Experienced new DBHDS staff has been hired to take on some of the most critical additional work needed to reform and build an enhanced service system. Stakeholders have been actively involved to ensure that their valuable perspectives, knowledge and expertise are considered in the deliberations of the many workgroups. The workgroups are designed to guide and provide oversight for implementation of the new initiatives. The Virginia Office of the Attorney General (VOAG) has maintained open communication and a problem solving approach with the

Department of Justice. This has facilitated shared understanding and progress on implementation of the requirements of the Agreement.

The Commonwealth had completed many important and necessary early steps when Judge John A. Gibney Jr. signed a temporary order entering the Agreement on March 6, 2012. These early actions reflect the level of commitment present among the leaders, General Assembly members, and other stakeholders whose support is essential to achieving compliance. The Governor had requested and the General Assembly had appropriated $60 million to begin implementation through the DBHDS Trust Fund. An interagency team was formed to oversee, support and coordinate its implementation. The DBHDS had begun a concerted effort to execute the Agreement's important initial provisions. The new FY12 HCBS Waiver slots had been created. DBHDS had committed to implement Crisis Services by implementing Systemic Therapeutic Assessment Respite and Treatment (START) to provide crisis services to individuals with ID/DD statewide. Case Management Core Competency Based Training Curriculum was being implemented, all Training Centers had begun using a new discharge planning processes, and the FY13 budget included $3 million to develop individual and family support services, and a one-time $800,000 fund for integrated community living options.

The DBHDS Commissioner and Senior Staff are leading an organized and concerted planning and implementation effort, as evidenced by the development of the Settlement Agreement Implementation Structure. Eighteen projects have been identified related to implementation. Each has a project team leader and is responsible for one or more specific Agreement requirement(s). Many have stakeholder committee members. A statewide overarching Stakeholder Group has been formed to promote communication, information sharing, and advice about implementation. After Judge Gibney signed and entered the final order on August 23, 2012, DBHDS developed a new system for gathering and notifying the Reviewer of serious injuries to former Training Center residents. DBHDS provided a DOJ Implementation Update July 23, 2012; a second update was published November 30, 2012. There has been considerable progress on the initiatives that were planned, funded and begun before the Parties signed and filed the Agreement on January 26, 2012.

The activities of the Commonwealth involve many stakeholders who are deeply committed to the target population and who are motivated to participate in implementation to ensure positive outcomes in their lives. The Commonwealth's involvement of stakeholders is important to the reform envisioned by the Parties and vital to long-term sustainability. Meaningful integration into community life for people with disabilities is supported by the collaboration and inclusion of valued members of the community. During the first reporting period, the interests of those with an investment in the work of the DBHDS have been highly visible and clearly expressed by their participation in and oversight of the reform efforts. With the implementation of the Agreement's provisions there will be more stakeholders with greater understanding. Individuals served will have opportunities to get to know their new neighborhoods and neighbors. New community partnerships will be formed, for example between the new crisis service teams and local hospitals, police departments, and others. An expanded number of business leaders and typical workers will become successfully engaged with individuals through supported employment. The collaboration with stakeholders, and the increased participation of the individuals in the fabric of community life, are the best hope for long-term sustainability of the provisions of the Agreement.

IV. INDEPENDENT REVIEWER

A. Duties and Responsibilities

The Agreement describes the Reviewer's duties and responsibilities in determining whether the Commonwealth is in compliance. He will conduct the factual investigation and verification of data and documentation. He will file a written report on the Commonwealth's compliance with the terms of the Agreement. The Reviewer's reports are due twice annually, on a six-month cycle, during the pendency of the Agreement. Additional reports of serious injuries and deaths of former Training Center residents are reviewed and submitted under seal to the Court with copies to the Parties and Intervenor's counsel. To complete these responsibilities the Reviewer, and the expert consultants retained, have full access to the Parties and stakeholders, as well as access to persons, employees, residences, facilities, programs, services, and all records, necessary to assess the Commonwealth's compliance. The Reviewer's first report to the court is due December 6, 2012, nine months from March 6, 2012, the effective date of the Agreement. The reporting period monitored in this report is between March 6, 2012, and October 6, 2012. The report is based on information received by November 30, 2012. The second reporting period extends from October 7, 2012, to April 6, 2013, with the second report to the Court due by June 6, 2013.

B. Methods and sources for gathering facts:

The Reviewer's facts and findings presented in this report come from a broad array of sources and methods. These include:

- observations during site visits;
- reviews of documents (e.g. policies, plans, training materials, records, forms, investigations);
- interviews (e.g. with officials, providers, staff, individuals, families);
- input from stakeholders (e.g. self-advocates, family groups, providers, CSBs, academics, researchers);
- self reporting (e.g. DBHDS summaries on progress, data, external consultant reports, reports on compliance); and
- individual reviews (e.g. expert consultant and clinician interviews with individuals, staff, site visit and review of discharge plans, individual support plans, monitoring reports, medical records).

Since Judge John A. Gibney signed an order temporarily entering the Agreement on March 6, 2012, until the writing of this report, the Reviewer has completed site visits and interviews with staff and individuals served in each of Virginia's five Training Centers, forty-six provider operated sites including day and residential programs, eight Community Service Boards (CSB), two regional crisis service programs, and two Centers for Independent Living. Site visits included observations of physical facilities, programs, and interviews with direct support professionals, program managers, senior staff, social workers, case managers, nurses, family members, individuals served, and others who are waiting for needed support.

The Reviewer prioritized f**or this first reporting period,** the most intensive monitoring for: Waivers, Case Management, Crisis Services, Integrated Day Activities and Employment First, Discharge Planning and Transition from Training Centers, and safety of those served in the community. The Reviewer has also monitored, though with less and varying levels of intensity, the initial planning and development activities of other major topics of the Agreement. These topics include individual and family supports, integrated housing, "barrier-busting" mechanisms (CIMs, CRCs and RSTs), and family-to-family and peer-to-peer programs.

How the Reviewer monitored each of these program provisions is described below.

For Crisis Services an independent expert was hired to complete a review of Crisis Services. The independent expert's "Crisis Service Requirements" report (Appendix B) focused on the aspects of the program development that were to be in place by June 30, 2012: Statewide Crisis System, Crisis Point of Entry, Mobile Crisis Teams, and Crisis Stabilization Programs. The review process consisted of extensive document review and interviews with key DBHDS and START Services staff. The reviewer has also made on-site visits, interviewed staff at two regional crisis services programs, and interviewed and read the quarterly report of the external consultant who is guiding this effort.

For Discharge Planning and Transition from Training Centers and **Case Management**, a Discharge Planning - Individual Review study (Individual Reviews) was designed that focused on fifty-nine individuals from a placement list provided by DBHDS. These are the individuals who moved from Southside Virginia Training Center (SVTC) and Central Virginia Training Center (CVTC) between November 2011 and June 15, 2012. A sample of thirty-two individuals was randomly selected from the community placement list using Random Sampler add-on software for Excel. The sample size was selected to provide a 90% confidence level and a 10% confidence interval, and therefore offers a sufficient degree of confidence that findings can be generalized to the fifty-nine individuals. A monitoring tool, a questionnaire was developed based on the requirements of the Agreement and DBHDS policies and procedures. The Individual Reviews were completed by a two-person team of experts, one of whom was a Registered Nurse with extensive experience working with individuals with ID/DD. The reviewers visited with and interviewed each individual and the staff present, and observed the quality and adequacy of the home environment. They also reviewed documents such as the discharge plan, post-move monitoring reports, individual support plans, and medical records. In addition, of the twenty-seven individuals who moved but were not selected in the random sample, the Reviewer and expert consultants visited twenty in their homes and/or day programs, bringing the total visited to fifty-two (88%) of the fifty-nine individuals.

It is important to note that the individuals in the Discharge Planning - Individual Review study transitioned from the Training Centers before the Agreement was final, and before the Discharge Planning and Transition provisions were required on July 1, 2012. This study, therefore, establishes a baseline from which to measure progress as system reforms and provisions of the Agreement are fully implemented and refined over time.

For the safety of the individuals who live in the community monitoring occurred in three ways: an Individual Review study was completed, reports of Serious Injury and Deaths

were reviewed, and the tracking process established by DBHDS for serious injuries and deaths was studied. Between July and September 2012 the Reviewer and expert consultants met face-to-face with fifty-two of the fifty-nine individuals who moved from the Training Centers to the community between November 2011 and mid-June 2012. The Discharge Planning - Individual Review study provides a sufficient degree of confidence that findings can be generalized to the fifty-nine individuals. The adequacy, quality, and safety of their homes were observed. Staff was interviewed and the individuals' discharge and support plans and medical records were carefully reviewed. For all the individuals who moved, the reports of serious injuries were reviewed. The Reviewer completed reviews of four individuals who have experienced injuries that required on-going medical care. The events that led to these injuries included falls, aspirations, and self-injurious behaviors. In each situation the DBHDS licensing specialists followed established procedures to investigate the injuries, completed unannounced visits, interviewed relevant staff, reviewed records, and if needed, developed Corrective Action Plans. Then they monitored implementation of recommendations. The Reviewer's findings have been reported to the Court under seal. Copies are shared with the Parties and the Intervenor's counsel. In addition to these monitoring activities, DBHDS has established a project team to address new licensure, human rights, risk management, and data analysis requirements.

The Reviewer's monitoring activities also included studying many plans, reports, policies, meeting agendas and minutes, tracking reports, incident reports, investigations, announcements, regulations, numerous records of individuals served, and consultant reports. In addition, the Reviewer interviewed officials, providers, consultants, staff, and individuals. He received input from key stakeholders, including CSBs, providers family groups, self advocates, etc. Finally, the Reviewer had regular and frequent, formal and informal, contact with the senior staff at the DBHDS and SHHR. These monitoring activities informed the Reviewer of the status of the topics monitored that are not described in detail above.

The Reviewer will monitor during the second review period, October 7, 2012 - April 6, 2013, compliance with the provisions of the Agreement. There will be more intense monitoring of the general areas of placements from the wait lists; transitions of individuals with DD under 22 years of age living in nursing homes and larger ICFs; integration; safety; and services to avoid unnecessary institutionalization. The specific provisions include completion of the Integrated Day Activities and Employment First implementation plan. They also include implementation of the Integrated Day Activities and Employment First policy. In addition, the specific provisions include the development of Community Living Options to provide independent housing; full implementation of the "barrier busting" provisions (Community Resource Consultants, Community Integration Managers; and Regional Support Teams); Quality and Risk Management; development of the Individual and Family Support program; and meeting the performance standards for Crisis Services.

The Reviewer will report twice annually during the pendency of this Agreement. Those reports will be public. The Commonwealth will publish and maintain these reports on the DBHDS website.

V. FINDINGS

For the Findings section of this report, the DBHDS was asked to provide data and documentation of its progress in meeting the requirements of the Agreement. Progress toward compliance was discussed in regular work sessions and meetings of the Parties during the first review period; progress was noted through observations during site visits; reviews of a wide array of documents; interviews with officials; input from stakeholders; reports from work groups and consultants, DBHDS reports on progress, and from Individual Reviews.

The Discharge Planning - Individual Review reports of the individuals in the sample have been distributed to the Parties. DBHDS is studying the review reports to determine appropriate actions. As Individual Reviews were completed, two issues of immediate concern were discussed with DBHDS staff who took corrective actions. As a result DBHDS also made adjustments to procedures and documentation requirements. During the term of the Agreement, it will be important to continue to focus on continuous improvement. Developing policies, procedures, staff training and monitoring practices that produce consistent quality results will require an evolutionary process. This process identifies shortcomings and ways of improving, and subsequently incorporates needed refinements.

Below are the Reviewer's findings regarding the status of the Commonwealth's initiatives and the next steps that must be taken to make progress toward compliance.

Waivers

"..shall create 60 waiver slots in FY12 to enable individuals in the target population in the Training Centers to transition to the community. (ii. 160 in FY13) Section III.C.1.a.i-ii.

"...create a minimum of 275 waiver slots in FY12...to prevent the unnecessary institutionalization of individuals with ID in the target population...or to transition to the community individuals with ID under 22 years of age from institutions other than the Training Centers (ICF's and nursing facilities)..(ii. 225 in FY13 of which 25 prioritized for those under 22 years of age in nursing facilities and the largest ICF's) Section III.C.1.b.i-ii.

"...create a minimum of 150 waiver slots in FY12 to prevent the unnecessary institutionalization of individuals with DD in the target population...or to transition to the community…under 22 years of age from institutions other than the Training Centers. (ii. 25 in FY13 including 15 for individuals under 22) Section III.C.1.c.i-ii.

The Commonwealth has complied with the requirements for establishing and distributing waiver slots the first reporting period. Sixty ID waiver slots were established and sixty-one individuals moved from SVTC and CVTC during FY12. One hundred and sixty waiver slots were established for FY13 to provide opportunities for current Training Center residents; forty-one of whom have moved to the community between July 1, 2012 and October 30, 2012. Not all the waiver slots were used as Money Follows the Person funds were used for individuals who moved to homes with four or fewer residents, and others moved to a community ICF or already had an assigned waiver. A determination will be made regarding "how unexpended balances associated

with the unused slots will be used to move forward with implementation of the Settlement Agreement."

To prevent the institutionalization of individuals with ID/DD, the Commonwealth met the requirement of providing 275 ID waiver slots during FY12 and established 300 for FY13, 75 more than was required by the Agreement. Of the waiver slots established in FY13, twenty-five are prioritized for individuals under 22 years of age. DBHDS distributed waiver slots to Community Service Boards (CSBs), which used them for individuals with ID on their urgent wait lists. The Commonwealth also met the requirement of providing 150 DD waiver slots during FY12 and twenty-five for FY13, which were distributed by DMAS to individuals on the DD waiver wait list. DBHDS and DMAS are working with the Centers for Independent Living and the Virginia Board for People with Disabilities to determine how to identify individuals in nursing facilities or community ICFs who would fill the FY13 waiver slots.

The individuals prioritized to move from SVTC and CVTC were those who expressed interest in moving to the community and for whom the provider capacity (i.e. appropriate homes, adequate staff resources and competencies, and well developed health and wellness management systems) existed to meet their needs. Though the sample of thirty-two individuals had substantial needs (thirteen (40.6%) were non-ambulatory and twenty-six (81.2%) were non-verbal), these individuals were not as a group representative of those with the most complex needs. Providers, many of whom have available vacancies and are seeking referrals, explain that they are not able to provide needed services to the individuals with the most complex needs with current funding rates and rate structure, except in larger congregate settings. Some providers rejected referrals of individuals with more complex needs.

Steps that must be taken to make progress toward compliance:

- identify individuals with DD residing in nursing facilities or community ICF's to transition to integrated settings during FY13; and
- take the steps necessary to ensure that those with the most complex needs are provided opportunities to live in the most integrated setting appropriate to their needs and consistent with their informed choice.

Case Management

"…ensure that individuals receiving HCBS waiver services…receive case management services, defined as:

Assembling professionals and non professionals who provide individualized supports, as well as the individual being served and other persons important to the individual being served…develop Individual Support Plans ("ISP") that are individualized, person-centered, and meet the individual's needs;

Assisting the individual to gain access to needed...services identified in the ISP; and

Monitoring the ISP to make timely additional referrals, service changes, and amendments to the plans...; Sections III.C.5.a.-b.

"…the case manager shall meet with the individual…as dictated by the individual's needs; and

…assess whether the individual's support plan is being implemented appropriately…and supports are being implemented…and…if inadequately…convene the individual's service planning team to address it… " Sections V.F.1-6.

Before the Agreement was finalized, the Commonwealth developed and implemented a statewide core competency-based training curriculum for case managers built on self-determination and person centered principles. As of September 30, 2012, a total of 2,750 DBHDS and CSB staff, case managers and private providers had completed all six of the modules that have been developed. Statewide performance standards are required by the Agreement. Currently, the case management services provided by 40 different CSBs, and by non-CSB case managers, are characterized, in part, by their different operating procedures, forms, case loads, and training. Case managers will fill an expanded and more vital coordination and accountability role in the future. Significant improvements are necessary to accomplish both the Agreement's required performance standards for case management, and the long-term goals of the Agreement. These performance standards apply to both ID and DD case management. The Reviewer has not yet had time to analyze the quality of the core competency-based training or the extent to which DD case managers have been trained.

Highlights from the Discharge Planning-Individual Reviews illustrate positive outcomes and areas of concern (see Appendix A: Individual Review-Discharge Planning Selected Tables for more data).

Of the sample of 32 individuals reviewed:

Positive outcomes related to the development and implementation of Individual Support Plans were:

- 32 (100%) were receiving case management services;
- 32 (100%) ISPs were current;
- 31 (90.6%) ISPs listed all their essential supports;
- 32 (100%) were receiving the medical supports identified in the ISP; and
- 31 (96.9%) were receiving the recreation services identified in the ISP.

Areas of concern related to the development and implementation of Individual Support Plans were:

- 10 (31.3%) were not receiving all the services identified in their ISP;
- 5 (27.8%) of the 18 individuals with identified concerns since moving have not had those concerns resolved;
- 10 (31.3%) were not receiving dental services;
- 3 (60%) of the 5 individuals with identified need were not receiving communication/assistive technology;
- 6 (19.4%) of 31 individuals were not receiving day services (could not determine for one); and
- 12 (37.5%) did not have evidence of personal décor in their room and other personal space.

Positive outcomes related to the individuals' homes were:

- 23 (95.8%) of the 24 individuals with identified need had been provided all needed supports for adapted environments and equipment;
- 31 (96.9%) of their homes were free of any safety issues;
- 32 (100%) of their homes were clean and had adequate food and supplies; and
- 30 (92.3%) of their homes were located near community resources.

The reviewers noted two other concerns that need further review. One is whether the objectives in some ISPs were measurable and sufficiently promoted the individual's growth and skill development. The other was whether staff in some homes provided the individuals sufficient habilitation, i.e. teaching skills and competencies to promote growth.

Steps that must be taken to make progress toward compliance:

- monitor implementation of the ISP to ensure timely additional referrals for medical professionals (e.g. dental examination, nutritional assessment), day services, and communication; to ensure that all individuals were receiving the supports identified in the ISP; and to ensure that staff are aware of and monitor the major side effects of psychotropic medications, including for tardive dyskinesia;
- ensure that all ISPs include objectives that are measurable and focused on the development of skills for increased independence; and
- ensure that all providers and staff provide sufficient habilitation to teach individuals skills and competencies that increase self-sufficiency and independence.

Crisis Services

The Independent Reviewer retained an expert consultant to review compliance with the crisis service requirements of the Agreement. That report "Crisis Service Requirements" (See Appendix B) is quoted in this section of the Reviewer's report. It describes the status of compliance efforts that were to be in place as of June 30, 2012, and areas of potential non-compliance with the Agreement, Statewide Crisis System, Crisis Point of Entry, Mobile Crisis Teams, and Crisis Stabilization Programs. The consultant's review process consisted of extensive document review and interviews with key DBHDS and START Services staff. The Reviewer monitored with on-site visits and interviewing staff at two regional crisis services programs, and by interviewing and reviewing the quarterly report, June 30, 2012 - September 30, 2012, of the external consultant guiding program implementation.

Crisis Services Section III.C.6.
Statewide Crisis System: Sections 6.a.i. ii. & iii;
Crisis Point of Entry: Section 6.b.i.B;
Mobile Crisis Teams: Section 6.b.ii.F.; and
Crisis Stabilization Programs: Section 6.b.iii.F.

The Commonwealth is commended for their efforts to implement crisis services and stabilization programs statewide, and for beginning their work before the Agreement was signed. DBHDS is also commended for deciding to use a "reliable, well-tested and comprehensive service delivery model, Systemic Therapeutic Assessment Respite and Treatment (START)" which provides a

"roadmap to meet the requirements of the Agreement and develop a statewide system to prevent, intervene and stabilize crisis situations..." DBHDS has initiated a "planning process and is providing leadership to enhance the state's ability to respond to the crisis needs of individuals who have ID/DD and a co-occurring mental health diagnosis or a behavioral challenge that places them at risk of institutionalization." Although "delays in program implementation have created a situation of only partial compliance the planning, organizational support, funding and well-conceived program design poise the state to implement successful crisis response in each region."

Full compliance with Sections 6.a.i, 6.a.ii, and 6.a.iii will be determined by how well staff in both the ID and Emergency Services divisions of the CSBs, providers and the START programs are prepared to address the needs of individuals with ID/DD who are at risk of or are experiencing a crisis. The Crisis Services Requirements report describes the training in crisis response and de-escalation required of staff who work directly with individuals who exhibit behavioral challenges including provider and CSB Emergency Services staff. Past analyses of the two models used, the Therapeutic Options of Virginia and Mandt System, have established their efficacy. Additional Positive Behavioral Support training is provided to behavioral consultants, teachers and case managers. START Services offers comprehensive training; and there are requirements for START staff to attend. START Coordinators must participate in all required training to become certified within one year of being hired. All these training approaches include the components that met the criteria established in the State Health Authority Yardstick (SHAY) to determine high quality training. The START training also includes quality elements of ongoing consultation and technical support.

The sufficiency and sustainability of funding for START Services is another measure of the Commonwealth's ability to meet the crisis system requirements of the Agreement. Funding of $7.8 million, rather than the $10 million initially planned for by DBHDS, and additional unused funds from the prior year have been made available for implementation of the START program. All regions are currently funded to implement crisis services and stabilization programs based on both normal delays in starting a program (i.e. hiring staff and preparing buildings) and some planned delay to fit available funding.

Although not part of the plan developed before the Agreement was settled, the DBHDS Commissioner issued a communication in June 2012 clarifying and directing that START services are available for adults with DD. However, to receive in-home supports or use the respite home one must have case coordination, i.e. a CSB case manager, DD case manager or other clinical home as called for in the START model. This requirement to have a case manager may exclude individuals from accessing START crisis intervention and stabilization support or to have funding to access other community supports to prevent crises in the future.

The existing CSB emergency services vary in several ways: resources available, competencies working with individuals with ID/DD, and whether they respond to crises in the home or on-site where the crisis occurs. These variations by location raise questions and challenges related to roles and responsibilities in their collaborations with the statewide START services and whether these services will meet the statewide requirements of the Agreement.

Crisis Point of Entry: Section III.C.6.b.i.

Each region has five to ten CSBs that currently provide 24/7 emergency responses. Each has a hotline to accept emergency calls and emergency staff to respond. "The type of response varies across the CSBs and regions as does the expertise to respond to the needs of individuals with ID/DD and behavioral challenges." The Inspector General for BHDS in 2010 reported that there was a serious gap in crisis stabilization for persons with ID.

All CSBs have a mobile crisis team that conducts face-to-face assessments; the majority only does so at the hospital emergency department. The CSBs are not required to go to an individual's home although this is the first level of response and the preference of the START Program, if the situation is deemed safe. The variance in CSB response on-site in people's homes has the potential to impact the capacity of the START Mobile Crises Teams to respond.

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

As of June 30, 2012, orientation sessions were provided using a standard power point orientation presentation and handout to describe the START program, the general referral process and a description of the resources. Thirty-seven of forty CSBs attended a regional open information session. START Directors in each region have oriented CSB emergency, ID and case management staff. As of October 30, 2012, DBHDS reports that 10-20% of START staff have been trained in regions one, two, and four; 30-50% have been trained in regions three and five.

Mobile Crisis Teams: Section 6.b.ii.
F. By June 30, 2012…shall have at least one mobile crisis team in each Region that shall respond to on-site crises within three hours.

DBHDS report that they are behind schedule, the Mobile Crisis Teams in regions three, four and five are in place and responding to crises. The Teams in regions one and two plan to begin operations in December 2012. As of October 2012, a reporting system is being implemented to track response time and other operational variables at the regional level. Data on response time are not yet available.

Crisis Stabilization Programs: Section III.C.6.b.iii.
F. By June 30, 2012…shall develop one crisis stabilization program in each Region.

DBHDS reports that the START crisis respite homes are under renovation or construction in all regions, and are behind schedule. The regions plan to begin operations as of November 2012 in region three (Southwest Virginia), December 2012 in regions one (Central Virginia) and two (Northern Virginia), in March in region four (Greater Richmond/Petersburg) and by June 30, 2013, in region five (Hampton Roads). Regions have partnership agreements with each other, so that programs coming online earlier can admit individuals from other regions, when beds are available.

Steps that must be taken to make progress toward compliance:

- develop a plan and provide sufficient resources to provide crisis services for children with either ID or DD and adults with DD that is not ID;
- ensure that adults with DD have case management to facilitate full access to crisis services and stabilization programs and access to community supports necessary to prevent future crises;
- ensure that crisis services meet the statewide requirements of the Agreement regardless of the variation between CSB emergency services capacity to respond (i.e. resources available, competencies working with individuals with ID/DD and whether they respond to crises in the home or on-site where the crisis occurs); and
- provide adequate funds for crisis service operations in FY14, including for mobile crisis teams in each region to respond to on-site crises within two hours by June 30, 2012.

Integrated Day Activities and Supported Employment

To the greatest extent practicable, the Commonwealth shall provide individuals in the target population… with integrated day opportunities, including supported employment. Section III.C.7.a.-b.

"…shall maintain it membership in the State Employment Leadership Network ("SELN")"
"...shall establish a state policy on Employment First ..;
"...shall have...one employment service coordinator to monitor implementation of the Employment First practices.."
"Within 180 days of this Agreement...shall develop…an implementation plan to increase integrated day opportunities…including supported employment, community volunteer…recreational opportunities, and other integrated activities."
"Provide regional training on Employment First policy and strategies..."

The Commonwealth has accomplished some of the Agreement's requirements in this section, although DBHDS has experienced difficulties and consequent delays in meeting other requirements. DBHDS has maintained its membership in SELN. It has also developed, and its Board has approved, an Employment First Policy that includes the elements required by the Agreement. The Employment First Implementation Plan was due on September 6, 2012. A Strategic Plan for Employment First was published on November 8, 2012. The Reviewer will review and analyze the plan more extensively during the second review period. The Reviewer's initial analysis is that the Strategic Plan includes important and helpful elements, such as long-range goals, perceived barriers and short-term objectives. However, compliance with the Agreement's provision for an implementation plan requires additional specifics. These elements are typically included in an implementation plan to ensure an efficient and effective implementation, such as agreed upon service definitions, identification of the party responsible for accomplishing each objective, the resources and support needed, and interim and measurable milestones. The Agreement also requires DBHDS to collect baseline data in a number of areas. This process has begun. Limited data has been collected on the number of people currently receiving supported employment services (not necessarily working), the length of time receiving supported employment, and the amount of earnings. The published plan did not establish targets to meaningfully increase the number of individuals enrolled in supported employment. In the assessment of the Reviewer, the limited data collected was adequate to set initial targets as part of

the plan, and that doing so, especially for the individuals receiving the newly established waivers, would encourage all stakeholders to increase these opportunities. DBHDS expects to establish such targets by March 31, 2013.

The DBHDS Strategic Plan for Employment First identifies current barriers to increasing supported employment. Identified barriers include that the Commonwealth's "rate setting and...policies and procedures…are not in line with federal guidance on supporting integrated employment." A desired result of implementation efforts is listed as establishing a "rate structure in line with CMS guidance which emphasized and incentivized delivery of employment services over other services." Commonwealth service providers report that it is much more difficult to provide supported employment under the waiver than it is under DARS. The Reviewer's opinion is that the current waiver structure inhibits the Commonwealth from readily expanding supported employment opportunities for people receiving services under the waiver and for those who want supported employment services and are waiting for new waiver slots to be distributed. (see Section VI of this report for Additional Information and Financial Considerations.)

Of the sample of 32 individuals reviewed:

Areas of concern related to the development and implementation of Individual Support Plans were:

- 11 (34.4%) were not receiving day services outside of their homes;
- 18 (85.7%) of the 21 individuals who were receiving out-of-home day services were in large congregated day centers, some of which were clustered on the same, or adjacent, property with group homes. Most provided little or no meaningful opportunities for participation in integrated day opportunities;
- two individuals for whom supported employment was recommended, the residential provider disagreed and has not pursued this option; and
- one individual who had a meaningful job when living at the Training Center lost the job when he moved to the community.

Steps that must be taken to make progress toward compliance:

- complete the Employment First Implementation Plan with the information required in the Agreement and the elements needed for a plan to be efficiently implemented;
- ensure that PST and case managers provide reliable information to individuals and Authorized Representatives regarding community options for integrated day services, consistent with Section IV.B.9., including the opportunity to discuss and meaningfully consider these options with peers, and their families, who are already living and involved in integrated day services in the community, before being asked to make a choice from among segregated only days service options;
- ensure that PST and case managers considering recommending options in a congregate day centers, consult with the CIMs, and Regional Support Teams if needed, to identify barriers to placement in a more integrated setting, to determine steps to take to address those barriers, and to request and receive assistance to propose appropriate options about how an individual's needs can be met in a more integrated day service setting; and

- ensure that the pre-move monitoring process plans for and the post-monitoring move process evaluates and verifies, and if needed recommends strategies so that, the individual is offered meaningful opportunities to discover interests and participates in integrated day activities.

Discharge Planning and Transition from Training Center

By July 2012…will have implemented Discharge and Transition Planning processes at all Training Centers… Section IV.A-D.

DBHDS has done extensive work in developing a standardized discharge planning process at all five Training Centers and in making progress toward compliance. Although the Agreement requirement is to have the discharge planning process in place as of July 2012 all Training Centers were utilizing new discharge planning processes as of March 2012. Note that the Discharge Planning-Individual Reviews referred to in this section were of individuals who transitioned before the due date of the Agreement requirements. The findings are based on on-site observations, interviews, and the review of documents provided.

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

DBHDS reports that all individuals residing at the Training Centers have a discharge plan. The Individual Reviews found that 32 (100%) had discharge plans, and that for 29 (90.6%) there was evidence of person-centered planning.

"…develop and implement discharge and planning and transition processes…" Section: IV.A.
"...individuals shall participate in ..discharge planning..." Section: IV.B.3.
"...final discharge plan developed within 30 days prior to discharge…" Section: IV.B.5
"...discharge planning will be done by the individual's Personal Support Team ..." Section: IV.B.6.

As the due date for the new discharge planning processes approached, the Individual Reviews indicated improvements in processes and documentation for those who transitioned in the final quarter of FY12. The processes utilized throughout FY12 demonstrated the strengths illustrated by the following data:

Of the sample of 32 individuals reviewed:

Highlights of positive outcomes related to discharge planning and transitions to the community were:

- 31 (96.9%) the individual and Authorized Representative participated in discharge planning;
- 31 (96.9%) updated their discharge plans within 30 days prior to the transition;
- 30 (93.8%) provider staff were trained in the ISP protocols transferred to the community;
- 28 (87.5%) all essential supports were in place before the move; and for
- 31 (96.9%) the necessary PST members attended the pre-move ISP meeting..."

Areas of concern related to the discharge planning were:

- 30 (93.8%) the discharge memo did not list all the key contacts in the community, including the licensing specialist, Human Rights Advocate, Community Resource Consultant and CSB support coordinator (Note: this was corrected in May 2012); and
- 7 (21.9%) did not identify all medical practitioners before the individual moved, including primary care physician, dentist and, as needed, psychiatrist, neurologist and other specialists.

"...individuals are served in the most integrated setting appropriate to their needs…" Section: IV.A.
"...propose appropriate options…how an individual's needs could be met in a more integrated setting." Section IV.11
"...In the event that a PST recommends...a congregate setting of 5 or more individuals…describe the barrier...the planned steps taken to address the barriers...refer to the Community Integration Manager (CIM)..." Section: IV.15

The Commonwealth assisted 117 individuals to move from Training Centers to the community between November 2011 and October 30, 2012. The Commonwealth has much to accomplish before it is serving individuals in the target population in the most integrated setting appropriate to their needs in accordance with their informed choice or ensuring that programs adequately promote community participation. In the assessment and experience of the Reviewer, providing integrated programs that promote community participation and inclusion is the Commonwealth's greatest challenge (see Section VI of this report).

Of the sample of thirty-two individuals reviewed:

Areas of concern related to the receiving services in the most integrated setting appropriate to their needs in accordance with their informed choice were:

- 11 (34.4%) moved to homes with five or more individuals;
- 11 (68.%) of the 16 individuals recommended to move to a residence of five or more, the barriers to placement in a more integrated setting were not identified; steps to address the barriers were not documented, nor was it documented that the matter was referred to the CIM;
- 4 (12.5%) of those who live with four or fewer, reside in homes licensed to serve five or more;
- 5 (15.6%) live in a cluster of group homes on the same or adjacent property;
- 10* (31.3%) were not provided adequate information regarding appropriate community options about how an individual's needs could be met in a more integrated setting;
- 30 (93.8%) were not provided opportunities to speak with individuals currently living in the community and their families;
- 16 (51.6%) of 31 individuals had not met their neighbors (could not be determined for one);

- 23 (82.1%) of 28 individuals go out primarily with their housemates as a group (could not be determined for four); and
- 30 (93.8%) did not belong to any community clubs or organizations.

*DBHDS has indicated that this occurred for more individuals, but documentation did not occur or was not provided.

Healthcare services are critical to the members of the target population, especially to those with complex needs. The Individual Reviews found many positive outcome areas of healthcare and some areas of concern. (See Appendix A Discharge Planning-Individual Reviews Selected Tables)

Of the sample of 32 individuals reviewed:

Highlights of positive outcomes related to the provision of healthcare were:

- 32 (100%) appointments were appropriately scheduled for medical practitioners and occurred within 30 days of discharge;
- 16 (100%) ordered by the physician, had a current psychological assessment;
- 8 (88.9%) of the 9 with clinical therapy recommendations were implemented or staff are actively engaged in scheduling appointments;
- 32 (100%) had a physical examination within the last 12 months;
- 30 (93.8%) had physician's recommendations implemented within the recommended time frame;
- 29 (93.5%) of 31 had medical specialist recommendations implemented within the time line recommended;
- 32 (100%) had lab work completed as ordered by the physician;
- 32 (100%) had diagnostic consults completed within the recommended time frame;
- 15 (100%) recommended by the physician were monitored by the provider for fluid intake;
- 14 (100%) recommended by the physician were monitored by the provider for food intake;
- 20 (100%) recommended by the physician were monitored by the provider for bowel movements; and
- 12 (92.3%) of 13 did not have evidence of excessive psychotropic medications.

Areas of concern related to the provision of healthcare were:

- 7 (21.9%) needed assessments that were not recommended;
- 11 (34.4%) did not have dentists' recommendations implemented within the time frame recommended;
- 7 (50%) of the records of the 14 individuals taking psychotropic medications did not include documentation of the intended effects and side effects of the medication;
- 12 (85.7%) of the records of the 13 individuals taking psychotropic medications did not include documentation of the legal guardian's informed consent;

- 10 (71.4%) of the 13 individuals were not monitored by a nurse or psychiatrist as indicated for the potential side effects of psychotropic medications, using a standardized tool at baseline and at least every 6 months; and
- 5 (35.7%) of 13 were not monitored for digestive disorders that are often side effects of psychotropic medication(s), e.g., constipation, GERD, hydration issues, etc.).

These areas of concern data illustrate that the health and wellness management systems of some service providers need to be strengthened. The Individual Reviews found positive outcomes that providers received extensive training from Training Center staff; however, those competencies were not always shared with all staff.

Steps that must be taken to make progress toward compliance:

- ensure that PST and case managers provide reliable information to individuals and Authorized Representatives regarding community options consistent with Section IV.B.9., including the opportunity to discuss and meaningfully consider these options with peers, and their families, who are already living in the community before being asked to make a choice regarding options;
- ensure that PST and case managers considering recommending options in a congregate residential setting of five or more, consult with the CIMs, and Regional Support Teams if needed, to identify barriers to placement in a more integrated setting, to determine steps to take to address those barriers, and to request and receive assistance to propose appropriate options about how an individual's needs can be met in a more integrated setting;
- ensure that the post-monitoring move process evaluates, and if needed recommends strategies so that, the individual is offered meaningful opportunities to discover interests and participate in community life;
- ensure that all of an individual's medical practitioners are identified before the individual moves, including primary care physician, dentist and, as needed, psychiatrist, neurologist and other specialists;
- ensure that all needed health assessments are recommended (e.g. annual dental exam, speech and language assessments for dysphasia, psychological assessments for self-injurious behaviors, and nutrition for significant weight fluctuations) and timely implementation of recommendations; and
- ensure that for individuals taking psychotropic medications support team members know the intended effects of the medications and that the potential side effects are monitored, including for digestive disorders and tardive dyskinesia, and that standardized tools are used at baseline and at least every six months.

Individual and Family Support Program

"…shall create an individual and family support program for individuals with ID/DD whom the Commonwealth determines to be most at risk of institutionalization". Section III.C.2.

The Commonwealth took important steps to create an Individual and Family Supports Program before and since the Agreement was settled. This included the first annual appropriation of $3 million in FY13. During the first review period a workgroup was established with a team leader

and stakeholder members. Regulations and an application have been drafted and are being reviewed for approval. To determine those most at risk of unnecessary institutionalization, the Commonwealth has established the criterion that an individual must be on the wait list to receive individual and family supports. After completing these essential preliminary steps, DBHDS expects to distribute funds to at least 700 individuals with ID/DD during FY13 as required. The Reviewer has not had the time, or the resources to engage an expert consultant, to thoroughly review the draft regulations. Based on the Reviewer's experience individual and family support programs that provide flexible and individualized funding is critical for individuals with ID/DD to sustain living independently or with their families, especially in the absence of other services, and to avoid unnecessary institutionalization.

During the second review period the Reviewer will monitor whether individuals with ID/DD, who are not on the wait lists are experience crises and are at risk of institutionalization, including medical, behavioral health, and correctional facilities.

Community Living Options

"…shall facilitate individuals receiving …waivers…to live in their own home, leased apartment…";
"…shall provide information and make appropriate referrals…";
"Within 365 days….shall develop a plan to increase access to independently living options…";
"Within 365 days….shall establish and begin distributing, from a one-time fund of $800,000 to provide and administer rental assistance…"

The Commonwealth appropriated and established a one-time $800,000 fund to provide rental assistance in accordance with the recommendations described in the Housing Plan, which DBHDS expects to complete by March 6, 2013. A full-time housing coordinator has been hired. He is the project leader for a work group that involves representatives from multiple state agencies and other stakeholders. National expert consultants have been retained to assist in developing this independently living program. An initial draft of a Housing Plan has been developed. The Commonwealth expects to complete the Housing plan by March 6, 2013, and to begin distributing funds during FY13.

In the Reviewer's experience programs that promote the use of truly integrated and independent (the lease(s) is in the name of the individual served and apartment mates) is very helpful at creating increased service options in the most integrated settings. It is the Reviewer's assessment that the Commonwealth has few service options between in-home services and congregate living. The development of supported apartments and shared living service options, typically for one to three individuals, could help fill that service gap. The revised HUD 811 program, for which the Commonwealth will receive extra points (due to the Agreement) in the competition with other states for these funds, offers a helpful potential resource. The Reviewer has not had time, or the resources to retain an expert consultant, to study the status of the current planning efforts. However, it is the Reviewer's experience that new statewide initiatives involving multiple agencies and local government entities are more challenging to implement than initiatives within a single agency. To be successful, such initiatives require a major commitment, a coordinated effort, and strong leadership to overcome conflicting interests. These frequently include different organizational goals, priorities, and incentives; different funding streams; and different definitions of services.

Family-to-Family and Peer Programs

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

The Commonwealth has created a Family Resource Consultant (FRC) who is in the process of developing a Family Mentor Network. This program will facilitate family members of Training Center residents to receive coaching on and support with the process of making the transition to the community from other volunteer family members who have successfully made the transition or people familiar with the ID/DD service system. DBHDS reports that a manual for training and providing resources to potential mentors, based on an existing model, has been drafted by the FRC. It is currently being reviewed for administrative approval. The first potential mentors and families interested in learning more about transitions to the community have been identified. One meeting was held with a community family group leader to discuss collaborative efforts. DBHDS expects to begin to match family mentors with reluctant family members and to seek further stakeholder input in December 2012. The Reviewer has not had time to review the draft manual. Based on the Reviewer's experience families and peers that have successfully made transitions can be very helpful to those who have not. There is a natural fear of losing a service that is known to pursue one that is not familiar. Having family members who once shared this natural hesitation provide information and anecdotes about the actual successes and challenges they experienced will help reluctant families make informed choices. The data from the individual reviews illustrate that the family-to-family and peer program was not in place during FY12.

Of the sample of 32 individuals reviewed:

- 30 (93.8%) individuals and their families were not provided the opportunity to speak with individuals currently living in the community and their families (could not determine for one).

VI. ADDITIONAL INFORMATION AND FINANCIAL CONSIDERATIONS

Today, there are many Virginians with ID/DD who have benefited from services that have helped them create opportunities, build relationships and improve their lives. Residential services have supported their personal skill development to become more self-sufficient and to live with greater independence. Employment programs have promoted skill development and opportunities to discover the capacity and satisfaction of meaningful work, earned income, and becoming a taxpayer. Advocates for an enhanced community-based service system highlight that those with the most complex needs can be, and are, supported in integrated settings that help people discover opportunities for meaningful participation in their communities. The essential challenge faced by the Commonwealth is that these options and outcomes are not yet readily available on a sufficient scale, or with the timeliness, that allows for a full realization of their benefits. This challenge is greater because of the Commonwealth's predominant funding mechanisms, rates and structure for the ID Waiver, Day Support Waiver, and DD Waiver.

In the early 1990s, prior to the use of HCBS Waivers, Virginia was becoming known nationally for expanding services that helped individuals move from congregate facilities to individualized and integrated service options in supported employment, supported apartments, and sponsor homes.

Since the early 1990s, the HCBS Waivers have created financial incentives over time to provide more residential and day services in larger congregate community-based facilities. As a result, a physical and human resource infrastructure has developed that contributes to individuals living less integrated lives than is appropriate for their needs. Once served in congregate facilities, the system gives no financial incentive to help individuals to develop their personal skills so they need fewer hours of services, or to move to more individualized and integrated community living arrangements.

Residential Services

The consequences of current HCBS waiver financial incentives are illustrated by the data in Table 1 about those living in group homes and community ICFs. A 2011 review of the Support Intensity Scale level of need of these individuals documented that more than 70% had average or below average needs. In addition, these data document that 72.3% of individuals living in congregate residential programs reside in group-residences of five or more, and that 12.5% live in congregate facilities of twelve or more. Also, some group homes are clustered on single or adjacent properties.

TABLE 1		
CONGREGATE RESIDENCES BY # OF OCCUPANTS		
Beds	**# of Locations**	**Total Bed Counts**
4-or less bed counts	457	1613
5-8	573	3477
9-12	33	365
13+	17	360

For residential providers the HCBS waiver rates have remained comparatively flat since being established in the early 1990s while the cumulative impact of inflation has increased costs. As inflation reduced the purchasing power of flat payment rates, service providers consolidated group homes. They closed some and increased the number of residents in others. Providers explain that "the way to make ends meet is to serve more people in each group home" and to "place group homes close together". Spreading fixed costs over a larger number of individuals served in one residence allows providers to more effectively manage cost pressures through years of flat funding rates. Today, providers report that they are actively seeking referrals to their group homes, many of which are licensed to serve more than the current number of occupants. Of the thirty-two individuals reviewed, twelve (37.5%) moved to group homes that are licensed to serve more residents than currently live there.

Providers of congregate residential services have a financial interest in continuing to serve the individual's currently living in their homes and to maintain or increase the number of hours of

services that are paid. If an individual becomes more self-sufficient and needs fewer hours of services, or choses to move to a community living option that offers greater independence, then the current residential provider loses revenue. Expenses may not be able to be lowered sufficiently to make up for the loss.

The financial structure encourages providers to serve people with average or below average needs, and to provide those services in larger group settings and to cluster multiple group homes together. The Commonwealth has admirably committed to person-centered policies and practices and has made a significant long-term investment in training and new processes. These efforts will more consistently lead to the desired outcomes for individuals when the situation for service providers includes financial incentives to move in that direction. Overall, the purpose of many programs is to help individuals become more self-sufficient and to live more self-determined and independent lives. When individuals can do more for themselves, they need fewer services and live more fulfilling lives. It also costs less to support them. This result is hampered because financial incentives do not align with these important goals for individuals.

Day Services

In the area of supported employment, until the early 1990s, the Commonwealth was viewed as a national leader in system development and capacity building. One of the original supported employment research and demonstration projects, Project Employability, was conducted in Richmond in the late 1970s. Replications of Project Employability took place in Virginia Beach and Norfolk in the early 1980s. Project Employability reportedly led to the first vendorship arrangement for a State Vocational Rehabilitation Agency. It enabled them to purchase supported employment services when the Virginia Department for Rehabilitative Services (VDRS, now called the Virginia Department for Aging and Rehabilitative Services) completed a vendor agreement with Virginia Commonwealth University, in approximately 1984. Vendor agreements were then initiated in the Virginia Beach, Norfolk, and Roanoke areas. In 1985, the Commonwealth won a competition for one of ten initial five-year supported employment system change grants awarded by the Federal Rehabilitation Services Administration. This grant funded an interagency partnership effort with the Virginia Department of Mental Health, Mental Retardation and Substance Abuse Services (now the Department of Behavioral Health and Developmental Services) to develop a statewide capacity to provide employment services supported by a coordinated system of training and technical assistance. In 1986, the Rehabilitation Act was amended to add Title VI.C, the State Supported Employment Services Grants, which provided funds to be used exclusively for the purchase of supported employment services. The VDRS vendor system then expanded substantially to approximately thirty-five vendors of supported employment services.

In the early 1990s the Commonwealth's funding system for persons with significant ID redirected the use of state and local dollars to match HCBS Waiver funds for Day Services. Advocates for individuals with ID/DD lament that, as a result, the use of state and local dollars for supported employment services became very limited. The Commonwealth's HCBS Waiver rate for supported employment services was a statewide fixed rate of approximately $16 per hour. The VDRS paid providers of supported employment services based on a negotiated rate that was much higher than the Waiver Rate. Employment Service providers would not accept the waiver rate. In 2008 the Department of Medical Assistance Services (DMAS) amended its waiver

funding for supported employment services to match the VDRS rate. However, providers report that it remains more difficult to provide services under the waiver. The State Employment Leadership Network reported in 2009 that "despite funding changing for Supported Employment through the Waiver, the service definitions don't match with DRS and some services billable under DRS are not billable under Waiver." Over the period from the early 1990s to the present, the overall supported employment effort fell far behind the need for this service among people with ID/DD as the Commonwealth moved to a predominant congregate services system. This is illustrated by the DMAS report of payment data in 2011.

TABLE 2

DAY SERVICES PAYMENTS BY PROGRAM MODEL 2011

Waiver	**Supported Employment**	**Pre-Vocational**	**Day Support**	Total
ID	$ 311,679	$ 646,833	$ 2,858,105	$ 3,816,617
Day Support	$9,282,288	$9,294,124	$75,016,706	$93,593,121
Total	$9,593,967	$9,959,960	$77,864,811	$97,409,703
% of total	**9.8%**	**10.2%**	**80%**	

Other aspects of the way services have been developed and the way funding is structured have created obstacles to delivering individualized services in the most integrated setting. One aspect is paying for day services in four-hour blocks of time. Another is requiring that an individual is served in either day supports or employment supports without the flexibility to move between the two programs.

The Bifurcated ID/DD Systems:

The current bifurcated ID/DD system contributes to confusion for families and inefficiencies for service providers. One state agency has paramount responsibility for individuals with intellectual disabilities and another for those with developmental disabilities. This is unhelpful for a family with a child with a developmental disability, but an unclear degree of intellectual impairment. They can be harmed by the advice of a well-intentioned professional who encourages the child to begin in the available DD services for which eligibility is clear. But when a diagnosis of an intellectual disability is established that the cognitive delay is more profound than hoped, the child loses DD eligibility. Although then eligible for ID services, the child would no longer be able to attend the program currently providing services. This is an example of how the system overwhelms a family. There are also many service providers struggling to provide efficient services for people with similar needs operating with two different sets of rules, regulations and monitoring systems.

Services in the most integrated setting:

There are examples of individuals with complex needs receiving supported employment and supported apartments in the Commonwealth, as there are across the United States. Staff and providers developed and maintain these programs within the current circumstances in Virginia. They are a valuable resource. Although they report feeling that they are "shoveling against the tide", they have delivered the positive outcomes that the Parties envision will result from the provisions in the Agreement. As the Agreement is implemented, the lessons they have learned can help others to develop the capacity and competencies to increase the scale and geographic

availability of supported employment and integrated community living options for individuals with a wider range of needs than is currently receiving these services and their benefits.

Service providers have explained that the financial pressures described above have led to the current community service system being comprised of mostly large group homes and day support centers. Developing this physical infrastructure has led to most staff being trained and oriented to work in congregate settings. It is important to mention that it is the Reviewer's impression that most service providers and staff throughout the Commonwealth work diligently to deliver quality and individualized services; though this occurs within the infrastructure that has been created.

The Reviewer's assessment and experience is that individuals with the most complex needs can be well served in integrated settings. Doing so depends on the adequate and flexible funding, the physical infrastructure needed (i.e. fully accessible homes, track systems for safety, lift equipped vehicles, emergency generators, etc.), the certified competencies of staff and the service providers' habilitation and health and wellness management systems. Successes occur more frequently when the financial incentives of the service system's funding structure are aligned with the desired outcomes for the individuals. As service systems change, initial successes will provide the confidence to develop more options that create opportunities, build relationships and improve lives.

VII. CONCLUSION:

In the Agreement the Parties committed to improve the lives of people with ID/DD by preventing unnecessary institutionalization and by providing them opportunities to live in the most integrated setting appropriate to their needs consistent with their informed choice. In the Reviewer's experience and assessment, this commitment will help them live as participants and valued contributors to their communities. The Parties also committed to reforming the service system so it is able to consistently promote these positive outcomes. The Reviewer has prioritized six aspects of the Agreement to monitor during the first review period:

1. Waivers
2. Case Management
3. Crisis Services
4. Integrated Day Activities and Employment First
5. Discharge Planning and Transition from Training Centers
6. Safety in the community

There has been much progress, though some delays, in achieving the requirements of the Agreement.

The Reviewer looks forward to the next phase of the Agreement during which the Commonwealth and stakeholders will develop and implement several additional provisions. Doing so effectively will take another important step toward compliance and achieving the goals of the Agreement.

VIII. RECOMMENDATIONS

Based on the findings in this report, the Reviewer recommends that the Commonwealth consider the following:

1. Review the current individual support planning process to ensure that sufficient measurable objectives are developed to increase individual skills, self-sufficiency and independence.

2. Strengthen service provider staff training and monitoring systems to support the health and wellness of individuals with the most complex needs. Doing so will increase the number of service providers and the range of service options with the capacity to support individuals at significant risk of aspirations, falls, constipation, and the major side effects of psychotropic medications, including tardive dyskinesia.

3. Add to the existing monitoring process periodic requirements that staff demonstrate the competencies needed to fulfill their role in maintaining the health of the specific individuals they support.

4. Add to the annual ISP process a review of the legal consent for psychotropic medications. This will ensure that the case manager, residential manager, and an individual's support team members are aware of the purpose of all psychotropic medications and needed monitoring for potential major side effects.

5. Add to the annual ISP review a discussion of strategies for creating more opportunities for exploring integration activities appropriate for each individual's interests and needs.

6. Recognize and support the staff and the providers who have successfully provided services that promote meaningful integration and participation in community life.

7. Review how other states' HCBS waivers are structured, and then amend and/or permanently modify the Commonwealth's waivers so the payment structure and rates encourage the service outcomes desired for individuals (i.e. living in the most integrated settings appropriate to their needs, and developing skills for increased self-sufficiency and independence).

Respectfully Submitted By:

Donald J. Fletcher
Independent Reviewer
December 6, 2012

APPENDICES

A. DISCHARGE PLANNING – INDIVIDUAL REVIEWS SELECTED TABLES

B. CRISIS SERVICES REQUIREMENTS

APPENDIX A.

DISCHARGE PLANNING – INDIVIDUAL REVIEWS SELECTED TABLES

DISCHARGE PLANNING – INDIVIDUAL REVIEWS
Fiscal Year 2012

DEMOGRAPHIC INFORMATION
of the sample of 32 individuals reviewed

Sex
Male 21 (65.6%)
Female 11 (34.4%)

Age ranges		
	n	**%**
21 to 30	1	3.1%
31 to 40	3	9.4%
41 to 50	9	28.1%
51 to 60	12	37.5%
61 to 70	6	18.8%
71 to 80	1	3.1%
81 to 90	1	3.1%

Levels of Mobility*		
	n	**%**
Ambulatory without support	12	37.5%
Ambulatory with support	7	21.9%
Uses wheelchair	12	37.5%
Confined to bed	1	3.1%
*totals more than 48 because some noted two levels of mobility		

Highest Level of Communication*		
	n	**%**
Spoken language, fully articulates without assistance	3	9.4%
Limited spoken language, needs some staff support	3	9.4%
Communication device	4	12.5%
Gestures- grabs	17	53.1%
Vocalizations	4	12.5%
Facial Expressions	1	3.1%
Other	3	9.4%
*totals more than 48 because some noted two levels of communication		

TABLE 3			
INDIVIDUAL SUPPORT PLAN			
Item	**n**	**Y**	**N**
Is the individual's support plan current?	31	100.0%	0.0%
Is there evidence of person-centered (i.e. individualized) planning?	32	90.6%	9.4%
Are essential supports listed?	32	90.6%	9.4%
Do the individual's goals and outcomes relate to his/her strengths, preferences and needs as identified in the assessments and his/her individual support plan?	32	84.4%	15.6%
Is the individual receiving supports identified in his/her individual support plan?	32	68.8%	31.3%
• Medical	32	100.0%	0.0%
• Recreation	32	96.9%	3.1%
• Mental Health	13	92.3%	7.7%
• Transportation	32	100.0%	0.0%
Have any identified concerns been resolved? (CND 5.6%)	18	66.7%	27.8%
Is there documented evidence of case management review, e.g. meeting with the individual face-to-face at least every 30 days, with at least one such visit every two months being in the individual's place of residence?	32	46.9%	53.1%

TABLE 4			
RESIDENTIAL ENVIRONMENT			
If the individual requires an adapted environment or adaptive equipment			
• Has all the adaptation been provided?	24	95.8%	4.2%
• Is the equipment available?	23	87.0%	13.0%
Is the individual's residence clean?	32	100.0%	0.0%
Are food and supplies adequate?	32	100.0%	0.0%
Is your home located near community resources (i.e. shopping, recreational sites, churches, etc.?)	32	93.8%	6.3%
Is the residence free of any safety issues?	32	96.9%	3.1%
Do you have privacy in your home if you want it?	32	87.5%	12.5%
Is there evidence of personal décor in the individual's room and other personal space?	32	62.5%	37.5%
Does the individual appear well kempt?	32	93.8%	6.3%

TABLE 5			
RESIDENTIAL STAFF			
Item	**n**	**Y**	**N**
Is residential staff able to describe the individual's likes and dislikes?	32	100.0%	0.0%
Is residential staff able to describe the individual's strengths, preferences and weaknesses?	32	96.9%	3.1%
Is residential staff able to describe the individual's health related needs and their role in ensuring that the needs are met?	32	96.9%	3.1%

TABLE 6				
DISCHARGE PLANNING				
Item	**n**	**Y**	**N**	**CND**
Did the individual and, if applicable, his/her Authorized Representative participate in discharge planning?	32	96.9%	3.1%	0.0%
Was the discharge plan updated within 30 days prior to the individual's transition?	32	96.9%	3.1%	0.0%
Was provider staff trained in the individual support plan protocols that were transferred to the community?	32	93.8%	6.3%	0.0%
Were all essential supports in place before the individual moved?	32	87.5%	12.5%	0.0%
Did the necessary Personal Support Team (PST) members attend the Pre-move Individual Support Plan meeting?	32	96.9%	3.1%	0.0%
• Individual	32	93.8%	0.0%	6.3%
• Case manager	31	96.8%	3.2%	0.0%
• Advocate	4	75.0%	0.0%	25.0%
• Staff who know the individual best	31	71.0%	0.0%	29.0%
• Authorized Representative	31	58.1%	41.9%	0.0%
• Post-Move Monitor or Discharge Coordinator	32	100.0%	0.0%	0.0%
Were all medical practitioners identified before the individual moved, including primary care physician, dentist and, as needed, psychiatrist, neurologist and other specialists?	32	78.1%	21.9%	0.0%

TABLE 7				
COMMUNITY INTEGRATION				
Item	**n**	**Y**	**N**	**CND**
If a move to a residence serving five or more individuals was recommended, did the Personal Support Team (PST) and, when necessary, the Regional Support Team (RST) identify barriers to placement in a more integrated setting?	16	31.3%	68.8%	0.0%
Was it documented that the individual, and, if applicable, his/her Authorized Representative, were provided with information regarding community options?	32	62.5%	31.3%	6.3%
Was it documented that the individual and, as applicable, his/her Authorized Representative, were provided with opportunities to speak with individuals currently living in the community and their families?	32	3.1%	93.8%	3.1%
Have you met your neighbors?	31	48.4%	51.6%	0.0%
Do you go out primarily with your housemates as a group?	28	82.1%	17.9%	0.0%
Do you belong to any community clubs or organizations?	32	6.3%	93.8%	0.0%

TABLE 8				
HEALTH CARE – POSITIVE OUTCOMES				
Item	**n**	**Y**	**N**	**CND**
Did the individual have a physical examination within the last 12 months or is there a variance approved by the physician?	32	100.%	0.0%	0.0%
Were appointments with medical practitioners for essential supports scheduled for and, did they occur within 30 days of discharge?	31	100.%	0.0%	0.0%
If ordered by a physician, was there a current physical therapy assessment?	2	100.%	0.0%	0.0%
If ordered by a physician, was there a current occupational therapy assessment?	2	100.%	0.0%	0.0%
If ordered by a physician, was there a current psychological assessment?	16	100.%	0.0%	0.0%
If ordered by a physician, was there a current speech and language assessment?	5	80.0%	20.0%	0.0%
If ordered by a physician, was there a current nutritional assessment?	12	83.3%	16.7%	0.0%
Were any other relevant medical/clinical evaluations or assessments recommended?	27	66.7%	33.3%	0.0%
Are clinical therapy recommendations (OT, PT, S/L, psychology, nutrition) implemented or is staff actively engaged in scheduling appointments?	9	88.9%	11.1%	0.0%
a. OT	2	100.%	0.0%	0.0%
b. PT	3	100.%	0.0%	0.0%
c. Speech/Language	5	100.%	0.0%	0.0%
f. Other	1	100.%	0.0%	0.0%
Did the individual have a physical examination within the last 12 months or is there a variance approved by the physician?	32	100.%	0.0%	0.0%
Did the individual have a dental examination within the last 12 months or is there a variance approved by the dentist?	32	93.8%	6.3%	0.0%
Were the Primary Care Physician's (PCP's) recommendations addressed/implemented within the time frame recommended by the PCP?	32	93.8%	6.3%	0.0%

TABLE 8				
HEALTH CARE – POSITIVE OUTCOMES -continued				
Item	**n**	**Y**	**N**	**CND**
Were the medical specialist's recommendations addressed/implemented within the time frame recommended by the medical specialist?	31	93.5%	6.5%	0.0%
Is lab work completed as ordered by the physician?	32	100.%	0.0%	0.0%
Are physician ordered diagnostic consults completed as ordered within the time frame recommended by the physician?	30	100.%	0.0%	0.0%
Does the provider monitor fluid intake, if applicable per the physician's orders?	15	100.%	0.0%	0.0%
Does the provider monitor food intake, if applicable per the physician's orders?	4	100.%	0.0%	0.0%
Does the provider monitor tube feedings, if applicable per the physician's orders?	4	100.%	0.0%	0.0%
Does the provider monitor seizures, if applicable per the physician's orders?	8	100.%	0.0%	0.0%
Does the provider monitor weight fluctuations, if applicable per the physician's orders?	13	100.%	0.0%	0.0%
Does the provider monitor positioning protocols, if applicable per the physician's orders?	9	100.%	0.0%	0.0%
Does the provider monitor bowel movements, if applicable per the physician's orders?	20	100.%	0.0%	0.0%
If applicable, is there documentation that caregivers/clinicians:				
a. Did a review of fluid intake?	10	100.%	0.0%	0.0%
b. Made necessary changes, as appropriate?	6	100.%	0.0%	0.0%
If applicable, is there documentation that caregivers/clinicians:				
a. Did a review of food intake?	14	92.9%	7.1%	0.0%
b. Made necessary changes, as appropriate?	10	80.0%	20.0%	0.0%
If applicable, is there documentation that caregivers/clinicians:				
a. Did a review of tube feeding?	4	100.%	0.0%	0.0%
b. Made necessary changes, as appropriate?	2	100.%	0.0%	0.0%
If applicable, is there documentation that caregivers/clinicians:				
a. Did a review of seizures?	5	100.%	0.0%	0.0%
b. Made necessary changes, as appropriate?	1	100.%	0.0%	0.0%
If applicable, is there documentation that caregivers/clinicians:				
a. Did a review of weight fluctuations?	13	84.6%	15.4%	0.0%
b. Made necessary changes, as appropriate?	9	77.8%	22.2%	0.0%
If applicable, is there documentation that caregivers/clinicians:				
a. Did a review of bowel movements?	21	100.%	0.0%	0.0%
b. Made necessary changes, as appropriate?	16	100.%	0.0%	0.0%
Is there evidence of a nourishing and healthy diet?	30	96.7%	0.0%	3.3%
If applicable, is the dining plan followed?	11	90.9%	0.0%	9.1%
If applicable, is the positioning plan followed?	6	100.%	0.0%	0.0%

TABLE 9			
Healthcare Items – areas of concern			
Item	**n**	**Y**	**N**
Are there needed assessments that were not recommended?	32	21.9%	78.1%
Were the dentist's recommendations implemented within the time frame recommended by the dentist?	30	63.3%	36.7%
If applicable, is there documentation that caregivers/clinicians: a. Did a review of weight fluctuations? b. Made necessary changes, as appropriate?	 13 9	 84.6% 77.8%	 15.4% 22.2%
If the individual requires psychotropic medication, is there documentation of the intended effects and side effects of the medication?	14	50.0%	50.0%
If yes, is there documentation that the individual and/or a legal guardian has given informed consent for the use of psychotropic medication(s)?	13	15.4%	76.9%
Does the individual's nurse or psychiatrist conduct monitoring as indicated for the potential development of tardive dyskinesia, or other side effects of psychotropic medications, using a standardized tool (e.g. AIMS) at baseline and at least every 6 months thereafter)?	12	33.3%	66.7%
Do the individual's clinical professionals conduct monitoring for digestive disorders that are often side effects of psychotropic medication(s), e.g., constipation, GERD, hydration issues, etc.?	13	69.2%	30.8%

APPENDIX B

CRISIS SERVICE REQUIREMENTS

The LEWIN GROUP®
Center for Aging and Disability Policy

REPORT TO THE INDEPENDENT REVIEWER UNITED STATES vs. COMMONWEALTH OF VIRGINIA

CRISIS SERVICE REQUIREMENTS

REVIEW PERIOD: JUNE 13, 2012- JUNE 30, 2012

Prepared by Kathryn du Pree, MPS
Vice President
Center for Aging and Disability Policy
The Lewin Group

Table of Contents

Introduction and Methodology

Donald Fletcher, Independent Reviewer for the US v Commonwealth of Virginia's Settlement Agreement, requested a review of the crisis system requirements of the Settlement Agreement. To accomplish this I proposed measures and evaluation methods to determine the state's compliance in this area. Many of the requirements will be met during the next 2 years as the statewide crisis system is implemented and the aspects of implementation will be evaluated semi-annually.

Currently Virginia is in the planning and early implementation stages of developing its crisis response system for individuals with intellectual disabilities (ID) and developmental disabilities (DD). This report focuses on those aspects of crisis system development that were to be in place by June 30, 2012. It is a review of:

- Statewide Crisis System: Sections 6.a.i. ii. & iii;
- Crisis Point of Entry: Section 6.b.i.B;
- Mobile Crisis Teams: Section 6.b.ii.F. and
- Crisis Stabilization Programs: Section 6.b.iii.F

A review process was developed that described the measurements and methods that would be used to determine the state's compliance with each requirement. The review process consisted of document review and interviews with key DBHDS and START personnel. The documents reviewed include: the RFP issued by the Virginia Department of Behavioral Health and Developmental Services (DBHDS) for regional START Crisis Prevention and Intervention Services, the regional proposals in response to the RFP, budget documents, descriptions of the START program, and training materials and documentation. The measures and methodology are contained in the "The Lewin Group's Proposal to Evaluate the Crisis Service Requirements of the US v Virginia Settlement Agreement": Attachment A. Interviews were conducted with:

Heidi Dix, Assistant Commissioner for Developmental Services, DBHDS

Bob Villa, State START Liaison, Office of Developmental Services, DBHDS

Gail Paysour, HPR I ID Crisis Services Project Manager

Lyanne Trumbull, HPR II Crisis Services Project Manager

Lucy McClandish, Region III Senior Director Intellectual and Disability Services

Denise Hall, Region III START Director

Ron Lucas, Region IV, START Director

Dona Sterling-Perdue, Region V START Director

Natalie Ward, Region V Senior Director Intellectual and Disability Services

Jarret Stone, Easter Seals of NC and VA, Liaison for START Services Regions I and II

Joan Beasley, Director, Center for START Services

This review was conducted within a 3 week timeframe and could not have been accomplished without the assistance of Bob Villa. He has been extremely gracious in terms

of his responsiveness and help to insure that I had the opportunity to speak to all of the key players in the regions who are responsible to implement START Services. Mr. Villa was always available to answer questions or to make pertinent documents available. He is very knowledgeable of the START program and the state's approach to implementing a well-coordinated crisis response system that will bring a consistent and proven approach to crisis prevention, intervention and stabilization to the service delivery system in Virginia for persons with intellectual disabilities. I also want to thank everyone who participated in the interview process. Their information and insight have been helpful in completing this review.

Virginia's Compliance with the Components of the Settlement Agreement

Section 6. a. The Commonwealth shall develop a statewide crisis system for individuals with intellectual and developmental disabilities

i. Provide timely and accessible supports to individuals with intellectual and developmental disabilities

ii. Provide services focused on crisis prevention and proactive planning to avoid potential crisis

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

Planning for the Development of the Crisis Services System

The Virginia DBHDS began planning for the development of a Crisis Intervention and Prevention statewide system in the summer of 2011 before the Settlement Agreement was completed or signed. To review the Commonwealth's compliance with this section I reviewed the state's requirements (as specified in the RFP issued for Regional START Crisis Prevention and Intervention Services), the state's funding to sustain these services, the provider's ability to proactively plan and provide crisis services (as detailed in the regional proposals and in the START Services materials), and the training for staff who will be involved in this endeavor.

The RFP and Regional Responses

The DBHDS contracted with the Center for START Services, University of New Hampshire, Institute on Disability, and issued a Request for Proposal (RFP). Each of the 5 regions was asked to respond by September 1, 2011 and awards were made by September 30, 2011. Start-up was to begin no later than January 16, 2012. DBHDS' contract with the Center for START Services included consultation with its Director, Dr. Joan Beasley. DBHDS made her available to all the regions for the development of their proposals.
The RFP included all elements to provide timely and accessible supports for persons with intellectual disabilities who have a co-occurring behavioral health need and are experiencing a crisis or at risk for institutional placement due to challenging behavior, providing in-home and community-based supports to help resolve crises and allow the person to stay in their current home or placement. It included the expectation that a

region-wide system would be in place with face-to-face assessment within 1 hour to individuals in need and access to crisis stabilization beds within 1 hour (urban)-2 hours (rural) by June 30, 2014. Regions were also to plan to provide in-home crisis supports for up to 72 hours. The DBHDS required each region to implement the national START model. All 5 regions provided proposals in response to the RFP and were granted awards. Regions III, IV and V are operating START programs through one of their Community Services Board (CSB), respectively New River Valley Community Services, Richmond Behavioral Health Authority, and Hampton- Newport News. Regions I and II decided to contract for the provision of START services with Easter Seals of North Carolina and Virginia that has experience operating START programs in North Carolina. In these regions one CSB functions as the fiscal agent: Region 10 CSB in Region I and Fairfax/Falls Church CSB in Region II.

Each Region's proposal was reviewed for this report. Regions responded regarding each of the specific components of the START model including the 3 primary service components: mobile crisis response, in-home crisis supports and the development of the respite home. Also described is how each region will undertake community education and family education, partner with existing community services and providers, and build effective community linkages to expand the capacity of the region's ability to prevent and respond to crisis for people with intellectual disabilities. Every region provided its plan to meet the expectations as articulated in the DBHDS RFP. A summary of the responses is provided in Attachment B: "Virginia DBHDS Region's Response to the START Crisis Prevention and Intervention Services". It includes a determination as to what degree the responses met the requirements. Each region has proposed a comprehensive approach to addressing the needs of individuals with ID who have a mental health diagnosis or behavioral challenges and who experience a crisis that can respond to the requirements of the Settlement Agreement.

The START Services Model

The START Services Model provides Virginia with the roadmap to meet the requirements of the Settlement Agreement and develop a statewide system to prevent, intervene and stabilize crisis situations for persons with developmental disabilities. It is a nationally recognized crisis intervention and prevention approach that has been in place since 1988 where it was first implemented in Massachusetts. It has since been implemented in New Hampshire, Connecticut, Ohio, Arkansas and North Carolina and is being considered by other states. It promotes serving people with co-occurring conditions in the least restrictive setting, providing 24/7 response to people experiencing a crisis with immediate telephonic access and in-person assessment within 2 hours of the call to the mobile crisis team, and clinical treatment, assessment and stabilization services both planned and emergency through short-term respite. It is a model that does not try to supplant what exists within a service delivery system but rather builds upon the existing crisis response system and strengthens it. The success of the model is based upon linkages and agreements with existing providers, cross system crisis prevention and intervention planning (CSCP), support and technical assistance to all of its community partners including individuals and their families and comprehensive systemic and clinical training with follow-up consultation. CSCP is an essential element of START that will enhance

Virginia's ability to respond to the Settlement Agreement requirements articulated in Section 6.a.ii and 6.a.iii. The CSCP is an individualized plan that specifies interventions to prevent crises and de-escalate and protect a person who experiences a crisis. It places a priority on crisis prevention planning through a collaborative process that builds the skills and confidence of caregivers and family members, while clarifying the role of professionals who are team members and increasing the team's ability to access timely emergency services.

START Services includes requirements for data collection that is standardized and outcome oriented. This information is shared quarterly with an Advisory Council that has the responsibility to review and analyze the data and provide input to shape continuous quality improvement efforts. Each region has established an Advisory Council that includes advocates, self-advocates, providers, regional staff, CSB staff and providers. These Councils are a key component to expand the expertise of the region to respond to crises, create system linkages and provide a review of the data that will lead to systems improvement. The data collection requirements of START will provide much of the information that will be needed by the Independent Reviewer to complete future reviews of the Commonwealth's ability to meet the requirements of the Settlement Agreement related to crisis service development and implementation.

Training

The ability of the Commonwealth and DBHDS to fully comply with the requirements of Sections 6.a.i, 6.a.ii, and 6.a.iii will be determined by how well staff in both the ID and Emergency Services divisions of the CSBs, providers and the START programs are prepared to address the needs of individuals with ID/DD who are at risk of or experiencing a crisis. The Independent Reviewer and I agreed that an initial review of available training would be included in this June, 2012 review. In order to review these training opportunities in a consistent fashion, I used criteria established in the State Health Authority Yardstick (SHAY). In order for high quality training to be provided the following components must be in place:

1. Credible and expert trainers
2. Active learning strategies (e.g. role play, group work, feedback)
3. Good quality manual
4. Comprehensively addresses all elements of the training topic
5. Modeling of practice for trainees, or opportunities to shadow/observe high fidelity clinical work delivered
6. High quality teaching aides/materials including workbooks, slides, videos, and handouts

DBHDS requires through licensing that training in crisis response and de-escalation be provided for all staff who work directly with individuals who exhibit behavioral challenges which includes provider and CSB Emergency Services staff. While this is not a requirement for case managers they are given the opportunity to participate. The majority of entities required to provide this to their staff use either the Therapeutic Options of Virginia (TOVA)

or the Mandt System. Therapeutic Options is the official crisis intervention and emergency support curriculum for the mental health systems of New Jersey, Oklahoma and Virginia, and for the developmental disability service systems for South Carolina, Vermont, Virginia and Washington. In Virginia the program is known as TOVA. Organizations send their staff to a 4 day- course to become certified instructors. Instructors in Virginia are required to be re-certified annually. The training is provided over 2 days emphasizing a team approach to crisis response and mitigation. Participants are provided a workbook and course outline and videos are used. Testing of knowledge and skills acquired occurs and supervision of staff carrying out the interventions is conducted. Two reports, one in 2004 from the Office of the Inspector General of Virginia, and a 2003 evaluation published in the Archives of Psychiatric Nursing, note its efficacy including data on the reduction of injuries to consumers and staff in the 2003 report. More information about the program is available at the organization's website: *http://therops.com*. The TOVA program includes all of the quality training components listed in the SHAY evaluation tool.

The Mandt System has been in operation since 1975 providing training to prevent workplace and relational violence. Staff are trained on crisis prevention through building healthy relationships, communication strategies and conflict resolution strategies, how to intervene in a crisis and how to stabilize a crisis situation. It is for practitioners, leaders, service users including family members, and direct support professionals. Technical instructors are certified and the program offers training to be an Advanced Technical Instructor. The training for participants is 5 days and includes lecture, demonstration, hands-on participation, role playing, small group work and self-study. Written materials and videos are used and updated every 2 years. Resources are available online and through CDs and DVDs. Competency are required and demonstrated through a test in which trainees demonstrate their skills. Participants must be re-certified every 2 years. More information about the Mandt System is available at the organization's website: *http://www.mandtsystem.com/*. The Mandt system includes all of the quality training components listed in the SHAY evaluation tool.

Additionally DBHDS has provided a grant to The Partnership for People with Disabilities at Virginia Commonwealth University to train persons who support individuals with disabilities in Positive Behavior Support Facilitation. This is intended for people providing behavioral consultation, including clinicians, teachers and case managers. Trainees must have a Bachelor's degree and 3-5 years of experience working with people who have disabilities and exhibit challenging behaviors. Classroom training is offered over 8 days and there is monthly group mentoring for trainees. Trainees must develop a portfolio that demonstrates their competence in Positive Behavioral Support Facilitation which is reviewed, along with an interview, as part of the endorsement process. Endorsement occurs within 12-15 months of initiating the training. The training topics include person-centered thinking, principles of behavioral analysis, developing supportive environments, team facilitation, functional behavioral assessment, data collection and analysis, crisis response, use of positive interventions and evaluation of their impact, and community system support. Using the SHAY Training Evaluation criteria referenced above this training program meets all of the components.

START Services provides comprehensive training through its Center for START Services at UNH/IOD. DBHDS has included access to this training thought its contract with the Center. There are requirements for START staff to attend the training and START Coordinators

must participate in all required training to become certified within 1 year of being hired, which is a condition of continued employment. Additionally, the National Online Training Series offers training modules to partners throughout the crisis services system including CSB staff including emergency services and case management, provider and families.
The certification process for START Coordinators includes 56 hours of training through courses and lectures, 50 hours of clinical supervision from the regional START Clinical Director and consultation from Dr. Beasley. Trainers affiliated with the Center for START Services are national experts in services and supports for people with co-occurring conditions. Training is provided on-site and online. As part of the comprehensive training there are 8 online sessions offered annually which are open to all START staff and all partners. Additionally all START team members have the opportunity to participate in 2 national meetings each year that is attended by all START programs throughout the country providing an opportunity for peer learning.
The START Training series has already begun in Virginia in addition to consultation and onsite meetings with Dr. Beasley. A 2 day training launch was offered February 15th- 16th and was repeated on May 23-24th. Various online trainings have been offered between March and June by Dr. Ann Hurley, Dr. Dan Baker and Dr. Joan Beasley who are all recognized experts in the field of co-occurring conditions and treatment. Topics included: Diagnoses of Psychiatric Disorders in Persons with Disabilities; Schizophrenia and Psychiatric Disorders and Intellectual Disabilities; Mood Disorders: Depression and Bi-Polar Disorders, Anxiety Disorders, Positive Behavioral Supports, Mental Health Aspects of I/DD and the Clinical Education Team, and Psychiatric Diagnostic Interview; Cross Systems Prevention and Intervention and the Role of the START Coordinator. Online training will continue to be available during the next fiscal year. The Center for START Services maintains attendance information on attendees. Additionally there are quarterly meetings convened by Dr. Beasley with each region and a monthly statewide call with all regional START Directors to provide consultation, technical assistance and peer review to improve crisis planning. The training offered by the National Center for START Services not only includes all the elements of quality training in the SHAY evaluation but also those that comprise the quality elements of ongoing consultation and technical support. This is to measure whether there is ongoing training, supervision and consultation for program leaders and clinical staff to support implementation and the development of clinical skills. These elements include:

1. Initial didactic training to clinicians
2. Initial agency consultation re: implementation strategies, policies and procedures including meetings with leadership
3. Ongoing training for practitioners to reinforce the application and address emergent practice difficulties until they are competent in the practice
4. On site supervision for practitioners, including observation and feedback
5. Ongoing administrative consultation for program administrators until the practice is incorporated into the routine workflow, policies and procedures of the agency

In addition to training, clinical consultation will be provided to the START Virginia Teams continuously. START Coordinators receive ongoing supervision to improve their skills in

systemic approaches, use of functional analysis techniques, and fostering the active communication and collaboration of all team members. A unique component of START is the Clinical Education Team Meetings (CET). This provides a monthly forum to improve the capacity of the local community to provide supports to individuals with ID/DD who have behavioral health needs through clinical teaching. All partners are included in this case review approach that uses actual crisis situations, while protecting the confidentiality and privacy of the person, to further learning in assessment, diagnosis, treatment and systems development.

The Sufficiency and Sustainability of Funding for START Services

Another measure that is important to the Commonwealth's ability to meet the crisis system expectations of the Settlement Agreement is the sufficiency and sustainability of funding for this new crisis service system. The majority of the funding is being provided by the Commonwealth through an appropriation to the DBHDS. Each regional START Program is expected to seek Medicaid and HCBS Waiver reimbursement as appropriate for services delivered that are covered by these funding sources. The original appropriation of approximately $10 million for FY13 was reduced to $7.8 million which was confirmed in Commissioner Stewart's 6/21/12 memo to Executive Directors and ID Directors of the CSBs, and to the START Regional Directors. However regions were also allowed to carryover unspent FY12 funding for the START project. Total funding includes carryover funds unspent in FY12 ($2.16m), the FY13 appropriation ($7.8m) and anticipated revenue from Medicaid ($2.56m). ***Table 1*** summarizes the original request for START funding from each region and the final allocations:

TABLE I: START Services Funding Summary

Region	Proposed Budget	Actual Budget
I	$1.85 M	$2.31 M
II	$2.79 M	$2.79 M
III	$2.90 M	$2.60 M
IV	$2.28 M	$2.24 M
V	$2.20 M	$2.53 M

The proposed budget amounts are what were included in the original proposal submitted in response to the RFP last fall. When the budget was reduced for FY13 all regions were asked to resubmit what they would need in addition to their carryover funds to operate. The amounts varied because regions are at different points of development and will be starting components of START services at different times during FY13 which will result in different costs for this year. All are currently funded for the amount they requested which was based on some level of delay.

Assistant Commissioner Dix reports that the department is committed to requesting the full annualized amount of funding needed for full operation of the START Programs for FY14. All regions are projecting adding an additional respite home and many propose to add to the mobile crisis teams and in-home support services depending on the level of need in the region. These proposed expansions may be necessary to meet the Settlement Agreement requirements for timely response to individuals with ID/DD and challenging behaviors experiencing a crisis. Future reviews shall include an analysis of the utilization data to determine the volume of crisis referrals to START and the regional programs' capacity to respond in a timely fashion to provide assessment and appropriate community supports. This will assist in determining the level of expansion that will be required in subsequent years.

The FY13 budget reductions are in part due to normal delays in starting a new program. It has not been possible for regions to establish and open the respite homes as projected, which is discussed under Section 6.b.iii.F in this report. However the budget reductions have also resulted in regions planfully delaying the hiring of staff and the implementation of the mobile crisis 24/7 response and the in-home supports, which is discussed in Section 6.b.ii.F. ***Table 2*** summarizes each region's status hiring START staff.

Table 2: Regional START Staff Hiring Summary

Region	Core Staff	In-Home Staff	Respite Home Staff
I	START Director: 6/25 Medical Director: identified Clinical Director: 9/12 Respite Director: 9/12 Clinical Team Leader: 8/12 START Coordinators: 7-9/12	Hire by 9/12	Hire by 9/12
II	START Director: 6/18 Medical Director* Clinical Director* Respite Director: interviewing Clinical Team Leader & START Coordinators: interviews begin 6/25/12	Hire by 9/12	Hire by 9/12
III	Director* Medical Director* Asst. Medical Director* Clinical Director* Respite Director*	In-home (2)* In-home (3): interviewing	Respite staff (8FTE)* Respite staff (7FTE): delay hiring until the home opens and is at full capacity

Region	Core Staff	In-Home Staff	Respite Home Staff
	Asst. Respite Director* Clinical Team Leader* Coordinators (6)* Coordinators (2): interviewing		
IV	Director* Medical Director* Clinical Director* Respite Director* Team Leader* Coordinators (4)*	Hire by mid-November	Hire by mid-November
V	Director* Medical Director* Clinical Director* Respite Director* Team Leader: 8/12 Coordinators (3)* Coordinators (2):7/12 Coordinator (1): not initiated Psychologist (PT): 8/12	Hiring process to begin 8/12	Hire 10/12-11/12including Assistant Director

**notes already hired at time of review*

The impact of the staff hiring process on the region's ability to implement the 3 major components of the crisis response system will be detailed in subsequent sections.

Areas of Potential Non-compliance with the Settlement Agreement:

It is evident that the Virginia DBHDS has undertaken a comprehensive planning process and the department is to be commended for adopting a nationally recognized model of crisis prevention and intervention. However there are two problematic areas.

Serving Children with Intellectual and Developmental Disabilities:

The Settlement Agreement requires the Commonwealth of Virginia to provide a crisis response system that can respond to individuals of all ages with ID or DD. Currently there is no plan or funding to provide crisis planning and response for children with either an intellectual or developmental disability. The START Program is designed for adults 18 years of age or older who have ID or DD and a co-occurring mental health diagnosis of behavioral challenge. Heidi Dix, Assistant Commissioner for Developmental Services, DBHDS discussed the issue of serving children with ID and DD with me during an interview conducted on June 26, 2012. She confirmed that there is currently no funding committed to provide crisis system's response to children under the age of 18 with either ID or DD. Children currently have access to EPSDT, Medicaid and those with serious emotional issues have access to wraparound services through the mental health division of DBHDS. These

existing funding streams provide a base upon which DBHDS believes comprehensive crisis prevention, intervention and stabilization could be added. The department plans to develop a proposal this summer and submit a budget option for the Governor to include in his budget proposal to the Legislature for FY14 which is presented in December 2012. The Legislative budget is finalized in March, 2013 and if funding for children's' crisis services is included it will be available in July, 2013. The DBHDS will need to decide if the START program can be adapted to serve children since its mission is to support adults with ID or DD or if an alternative model will need to be developed.

Serving Adults with Developmental Disabilities:

The Settlement Agreement requires the Commonwealth to provide crisis system support to individuals with developmental disabilities as well as intellectual disabilities. Currently the Commonwealth is not in full compliance with this requirement. The DBHDS is the agency responsible to serve people with intellectual disabilities but not those who have a developmental disability. A recent communication was issued on June 21, 2012 by DBHDS Commissioner James W. Stewart, III to clarify access to START Services for Individuals with Developmental Disabilities (Attachment C). He directs that individuals with DD are to be offered START Services and clarifies that this population was not addressed in the original RFP as the department was not aware of the full requirements of the Settlement Agreement at the time the RFP was issued.

The criteria for persons with DD to access START indicate that all can be referred to START, have a face to face assessment and be referred to other resources. However, to receive in-home supports or use the respite home you must have a CSB case manager, DD case manager or other clinical home (case coordination) as called for in the START model. This requirement to have a case manager may exclude individuals with DD from accessing START crisis intervention and stabilization support or have funding to access other community supports to prevent crises in the future.

Individuals with ID are eligible for HCBS waivers and are provided case management as a Medicaid State Plan service. Individuals with ID are provided case management through the CSBs and will have full access to START Services. If a person with ID who was not previously known to the system and does not have a case manager requests support during a crisis, Bob Villa has reported that the CSB will assign a case manager within 3 days to coordinate with START services and community support linkages.

Adults with developmental disabilities are not currently served by DBHDS although both Deputy Commissioner Dix and Bob Villa, DBHDS START Services Liaison, confirm that it is the long range plan of Virginia to include this population under the DBHDS authority. Currently, a limited number of individuals with DD (1,000) are on a waiver operated by the Department of Medical Assistance Services (DMAS), the state Medicaid agency, and have a DD Waiver Case Manager. Others who have a mental health diagnosis and are in crisis are connected to Behavioral Health Case Management through DBHDS. Individuals with DD are not eligible for case management through the state plan so they only have a case manager if they are a waiver participant or part of the mental health system. The administration of DBHDS is clarifying whether DMAS plans to activate case management for an individual with DD who is in crisis and referred for crisis system support who has no case manager assigned. If not they will not be able to access START services under the current criteria.

Individuals need not only access to case management to be served by START but need access to community supports upon which the START program components build to help stabilize the individual and allow them to remain in the community. START is well qualified to serve individuals with DD and makes no distinction between individuals with ID and DD in terms of the responsiveness of the model. Data on the number of people experiencing crises and referred to START will need to be reported that includes these individuals access to case management, community services and adequate funding to continue to support them in their communities and avoid unnecessary hospitalizations as the Settlement Agreement is implemented.

Compliance with Section b.i. Crisis Point of Entry

A. The Commonwealth shall utilize existing Community Services Boards (CSB), including existing CSB hotlines, for individuals to access information and referrals to local resources. Such hotlines shall be operated 24 hours per day, 7 days per week and staffed with clinical professionals who are able to assess crises by telephone and assist the caller in identifying and connecting with local services. Where necessary, the crisis hotline will dispatch at least 1 mobile crisis team member who is adequately trained to address the crisis.

Each region has between 5-10 Community Services Boards (CSB) that are currently responsible to provide 24/7 emergency response to crises for individuals within their catchment area including people who have intellectual disabilities. Each CSB has a hotline which accepts emergency calls and emergency services staff who respond. The type of response varies across the CSBs and regions as does the expertise to respond to the needs of individuals with ID or DD and behavioral challenges. One of the regions highlighted a 2010 report from the Commonwealth of Virginia's Office of the Inspector General for Behavioral Health and Developmental Services in its explanation of the need for the START Program. The Inspector General noted in a report entitled: "Review of Residential Crisis Stabilization Units Operated or Contracted by CSBs" that there is a serious gap in crisis stabilization for persons with intellectual disabilities. All regions operate crisis stabilization units for persons with mental health diagnoses who are in need of short term placement for treatment and stabilization. Some of these units are able to respond to the needs of individuals with ID. Region II has a unique program to support people in crisis including people with ID. They offer a Clinical Support Team staffed with a psychiatrist, social worker and funding for behavioral supports. They provide consultation for people living at home, comprehensive assessments, crisis behavioral plans and consultation to other providers.

Regions reported that while all CSBs have a mobile crisis team that conducts face to face assessments, the majority of CSBs will only do so at the hospital emergency department. Less than 50% will respond on-site to a crisis in another community location including group homes or an individual's personal residence as is summarized in ***Table 3***.

Table 3: CSB Mobile Crisis Team Response by Location

Region	Onsite response to a hospital	Onsite response to person's home or community location
I	8	4
II	5	3
III	10	0
IV	8	4
V	9	6

The premise of the START Program is that it will have a 24/7 response capacity and will accept referrals from the CSB Emergency Services (ES) Mobile Crisis Teams. START is modeled on a cooperative response that involves the CSB Emergency Services staff. The determination of whether someone in crisis needs hospitalization is the responsibility of the ES Mobile Crisis Team, not the START team. For those people experiencing a crisis who are not in need of hospitalization or for whom that may depend on the availability of other supports, the CSB ES Mobile Crisis Team is expected to contact the regional START program and coordinate the response to the crisis. However, the CSBs are not required to go to an individual's home although that is the first level of response and the preference of the START Program if the situation is deemed to be safe. The funding levels vary for the CSBs as one of the funders is the local jurisdiction which may provide more funding but is only obligated to fund 10% of the CSBs operating costs. This disparity in funding contributes in part to the varying capacity to respond. From an interview with Bob Villa I learned that each CSB has a MOU with the region acknowledging that the CSB has a role to collaborate with the regional START Program to respond to crises for people with ID. Since each CSB responds differently to crisis referrals the region is expected to also develop an affiliation agreement with each CSB in its area. A template for this agreement has been developed by DBHDS (Attachment D). This outlines the responsibilities of both emergency response teams to work collaboratively to provide quality crisis intervention and divert people with ID from hospitalization when clinically appropriate to do so. Nine responsibilities of the START Program are specified in the template. The ES/CSB agrees to provide 24/7 response, contact the regional START Program, work to develop the Cross System Crisis Plan, participate in team meetings and relevant training, and arrange for an inpatient psychiatric setting when clinically and systemically appropriate. It should be noted that this agreement only speaks to serving adults with ID.

What will be unique in each affiliation Agreement is what the individual CSB commits to as its particular response to these crises including locations where they agree to respond. The requirement that each CSB have an Affiliation Agreement with the regional START Program is positive in that roles will be delineated and clarified. However, the variance in CSB

response has the potential to impact the organization of the START Mobile Crisis Teams and each team's capacity to respond. Will START Coordinators respond onsite in people's homes without being accompanied by the CSB ES staff? Will this have an impact on START resources and ability to respond within the timeframes expected if Coordinators must accompany one another rather than work independently accompanied by a CSB ES clinician? Will START Coordinators only respond at sites to which the CSB ES staff will go? Will this have an impact on the person in crisis or his family if they may have to go to a hospital setting unnecessarily to have a face to face assessment of their need for crisis intervention?

It was not possible during the course of this initial review to determine if all CSB staff are adequately trained to respond to the crisis intervention needs of individuals experiencing a crisis. Throughout the implementation of this agreement START training should be continuously offered and required of ES personnel to enhance their understanding and expertise in addressing the needs of individuals in crisis who have co-occurring conditions to build an effective systemic response and successful collaboration between the CSB and START mobile crisis teams as they respond to referrals for crisis intervention and stabilization.

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

DBHDS made a commitment early in the planning process to provide training to CSB emergency personnel in each region about the aspects of the START Program. Bob Villa made 2 presentations to the Virginia Association of Community Service Boards (VACSB) in January and May of 2012. A standard power point presentation and handout were used that describe the START Program, the general referral process and a description of resources. Additionally each region scheduled an open information session for all of its CSBs between January and May of this year. Documentation was provided by DBHDS and 37 of the 40 CSBs attended one of these regional sessions. Region III invited other emergency personnel including law enforcement to the overview session. Regional START Directors have also met individually with CSB emergency, ID and case management staff to provide an overview to START Services. Ongoing communication and training between the START staff and all of their partners including the CSBs is a priority of DBHDS central administration and regional START staff.

Section 6.b.ii. Mobile Crisis Teams:

F. By June 30, 2012 the Commonwealth shall have at least 1 mobile crisis team in each Region that shall respond to on-site crises within 3 hours:

None of the regions have been able to fully comply with this requirement due to delays in hiring and budget reductions. Regions III, IV and V have started to provide some level of consultation and mobile crisis response mostly for individuals at risk of behavioral crises but not currently experiencing a crisis. ***Table 4*** below provides a summary of each region's plan for its mobile crisis team to be fully operational and what level of support has been available as of June 30, 2012. Also included in this Table is the status of offering in-home

supports for up to 72 hours for a person experiencing a crisis that can remain in her existing residence.

It should be noted that every region expects to respond within 3 hours to provide a face to face assessment and some regions plan to respond within 2 hours once the mobile crisis team is fully operational. However all regions reported the challenges of accomplishing this as a result of the dispersed geographic nature of their region or the congestion and traffic. Some regions are hiring staff that live in different parts of the region to be in greater proximity to more individuals, other regions are dispersing their staff's worksites to shorten their response time. Region III is exploring technology and video-conferencing as a potential aide to providing timely consultation and follow- up.

Section 6.b.iii. Crisis Stabilization Programs:

F. By June 30, 2012 the Commonwealth shall develop one crisis stabilization program in each region.

Currently no Respite Home has been opened by a regional START Program in compliance with the requirement to have a crisis stabilization unit program in each region by June 30, 2012. Three of the regions have purchased or already owned homes that are suitable for use as a respite home. Region IV is purchasing a home and is scheduled to close on July 12, 2012. Region V owns property and is building a home that will meet the criteria for the environmental considerations of the START model. Summaries of the regions' status to develop a crisis stabilization program are contained in ***Table 4***.

Table 4: Summary of Regional START Program Implementation

REGION	Mobile Crisis Response	In-home Support	Respite Home
I	8/12 Will respond within 3 hours	9/12-10/12	10/12 opening for 3 1/13 expand to 6 Home owned, renovations needed
II	Awaiting licensing Will respond within 3 hours	9/12-10/12	10/12 opening for 4 1/13 expand to 6 if funded Home purchased, needs renovations
III	Provides mobile crisis response 7:30AM-6PM 7 days Will be 24/7 by 9/15/12 Will respond within 2 hours	Provides in-home non crisis response 7:30AM-6PM 7 days Will be 24/7 by 9/15/12	9/15/12 opening for 4 1/13 expand to 6 Home purchased, renovations scheduled to be completed by 9/1/12
IV	Currently accepting non-crisis referrals (25 to date) and can respond to crisis during the day By 7/15/12 extend to 7PM	1/1/13 delayed start due to budget reduction	1/13 opening for 6 Accepting referrals for planned respite 10/12 for January

REGION	Mobile Crisis Response	In-home Support	Respite Home
	Will be 24/7 by 8/15/12 Will respond within 2 hours		Closing on home 7/12/12, needs renovations
V	Providing consultation for non-crisis referrals (10 to date) By 7/15/12 will accept crisis referral, extend hours to 7PM Will be 24/7 by 9/1/12 Will respond within 2-3 hours	10/1/12 will start supports with partial staffing in place	1/13 opening for 5-6 Home to be built, property purchased, architectural plans complete

Conclusion

The Commonwealth of Virginia's DBHDS has initiated a planning process and is providing leadership to enhance the state's ability to respond to the crisis needs of individuals who have ID and DD and a co-occurring mental health diagnosis or a behavioral challenge that places them at risk of institutionalization. They are to be recognized for starting this process several months before the completion of the Settlement Agreement and for deciding to use a reliable, well-tested and comprehensive service delivery model, START Services. This offers the potential to build communities' capacity, expertise and ability to respond in a timely and positive manner to individuals in crisis and support them to remain in their home communities. The leadership of DBHDS, Office of Developmental Services including the START Directors is very committed to creating a successful service delivery model based upon the tenets of the START Model. Although delays in program implementation have created a situation of non-compliance the planning, organizational support, funding and well-conceived program design poise the state to implement successful crisis response in each region within the next 6 months.

Future reviews of this requirement of the Settlement Agreement will need to include an analysis of the existing community service delivery partners' ability to enhance and expand their ability to coordinate and provide ongoing community support to individuals at risk of crisis and those who experience crisis and need emergency support. The START program will need these formal partnerships in order for the system to be able to maintain people with co-occurring conditions at home and within their communities so that they do not experience unnecessary institutionalization.

Attachment A: The Lewin Group's Proposal to Evaluate the Crisis Service Requirements of the US v Virginia Settlement Agreement

Kathryn du Pree, Vice President of The Center for Aging and Disability Policy has been asked by Donald Fletcher, Independent Reviewer for the US v Commonwealth of Virginia's Settlement Agreement, to propose an approach to evaluate the crisis system requirements of the Settlement Agreement. The following outlines the expectations of the Settlement Agreement related to the development of a statewide crisis system for individuals with intellectual disabilities (ID) and developmental disabilities (DD) which are contained in section 6. Following each subsection are recommended measures and a suggested method to determine the states' compliance.

Settlement Agreement Requirements:

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

i. ***Provide timely and accessible support to individuals with I/DD who are experiencing crises, including crises due to behavioral or psychiatric issues, and to their families;***

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

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

Initial review of these requirements will include:

- The state's contractual requirements for the timely response to calls to the crisis 24 hour line
- The state's contractual requirements for the timely response of the crisis intervention team to assess the individual's needs and initiate services and supports
- The state's plan to assure proactive planning to avoid crises: requirements to assess consumers for potential behavioral or psychiatric crises, requirements to address prevention in the individual planning process, training for case managers and other team members in prevention approaches
- The provider's ability to provide the crisis services within the timeframe established by the Settlement Agreement
- The sufficiency and sustainability of the state's funding for the establishment and ongoing operation of the components of the crisis system
- The sufficiency of the provider's plans to develop crisis response including time requirements, staffing availability and expertise, assessment protocols, intervention strategies for the individual and family, and approaches designed to keep the person in their current setting

Method: The expert will review written documents including the RFP issued by the Commonwealth, the responses of the chosen providers, and the allocated funding for the

crisis system; and training requirements for case managers in crisis prevention approaches.
The reviewer will interview the Program Director for each Region's START Program to assess status of development, the adequacy of the provider's plan to provide all required aspects of crisis services, and the ability to meet the timelines of the Settlement Agreement.
Measurements to assess the provision of crises services during the course of the settlement agreement:

- Individual plans include identification of behavioral needs and include prevention strategies
- Crisis response is timely when requested and includes an assessment and intervention plan
- In-home services are started when required and continue until the person is stabilized
- Training of family caregivers occurs
- Transition planning occurs when the person must leave his or her current setting for crisis stabilization
- Transition planning occurs when the person has a short term hospitalization to facilitate the return home
- Crisis intervention services are communicated to and coordinated with other service providers involved in supporting the individual

Method: The expert will review aggregate data for each measure and will select a random sample of 10% (minimum of 10 per region) of the individuals referred to each region's crisis intervention program to review the data related to each measure and will conduct a phone or in-person interview with 2 families, 2 case managers and 2 providers in each region.
Settlement Agreement Requirement:
6. b. The crisis system shall include the following components:

i. Crisis Point of Entry

A. The Commonwealth shall utilize existing CSB Emergency Services, including existing CSB hotlines, for individuals to access information about and referrals to local resources. Such hotlines shall be operated 24 hours per day, 7 days per week and staffed with clinical professionals who are able to assess crises by phone and assist the caller in identifying and connecting with local services. Where necessary, the crisis hotline will dispatch at least 1 mobile crisis team member who is adequately trained to address the crisis.

Measures:

- The number and location of CBS Emergency Services and hotlines
- The availability of this resource to individuals with I/DD and their families as evidenced by a summary of individuals using the service and hotline by diagnostic category and data as to any denials of request for service
- A plan and protocols exist for referral to the new crisis response system (START mobile crisis teams)

Method: The expert will review data provided by the state or each CBS Emergency Service

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

Measures:

- A curriculum to explain the system, address referrals and available resources
- All identified CSB emergency personnel in each region have been trained

Method: The state will provide the curriculum used and documentation of the dates of training and the attendees by profession which will be reviewed by the expert.

Settlement Agreement Requirement:

ii. Mobile crisis teams

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

Measures:

- A training curriculum for all crisis team members is available and addresses crisis assessment, treatment approaches, and in-home and family support techniques
- Training has been provided to all team members
- Staff competency in the training materials has been assessed

Method: The expert will review the training curriculum and documentation submitted by each region confirming that training has occurred.

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.

Measures:

- The number of individuals calling or referred to the mobile crisis team
- The number of crisis plans developed
- The elements of the crisis plan and the number that include short-term in-home services
- The number of individuals using the mobile crisis team that were maintained in their current setting
- The number of individuals using the mobile crisis team who were transitioned to another appropriate community setting
- The number of individuals using the mobile crisis team who required ER services
- The number of individuals using the mobile crisis team who required an inpatient hospitalization

Method: The expert will review data provided by the region including a random selection of 10% (minimum of 10 per region) of the individual crisis plans.

Settlement Agreement Requirement:

C. Mobile crisis team members adequately trained to address the crisis also shall work with law enforcement personnel to respond if an individual with ID/DD comes in contact with law enforcement

Measures:

- There are outreach efforts by the mobile crisis team to local law enforcement to provide information regarding treating individuals with ID or DD
- The number of individuals with ID or DD experiencing a crisis who are arrested or sent to an ER by a law enforcement officer
- The number of individuals referred to the mobile crisis team by a law enforcement officer
- The number of individuals served by the mobile crisis team who were in contact with law enforcement who remained in a community

Method: The expert will review encounter data submitted by the region and documentation of any outreach efforts.

Settlement Decree Requirements:

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

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

Measures:

- The number of calls received by the mobile crisis team, the time of day the call is received and the time in which the call is answered
- The number of calls that result in an on-site response and the ability of the crisis team to respond in a timely manner
- The determination through the assessment process of the duration and type of in-home support needed
- The length of time in-home support was provided
- Consumer and family satisfaction with the telephonic and on-site response to a call to the mobile crisis team

Methods: The expert will review data provided by the regions, and will develop and administer a short telephone survey to a random selection of 10% (minimum of 10 per region) of the individuals and families served by the mobile crisis team to determine their satisfaction.

Settlement Decree Requirements:

F. By June 30, 2012 the Commonwealth shall have at least one mobile crisis team in each Region that shall respond to on-site crises within three hours.

G. By June 30, 2013 the Commonwealth shall have at least two mobile crisis teams in each region to respond to on-site crises within two hours.

H. By June 30, 2014 the Commonwealth shall have a sufficient number of mobile crisis teams in each Region to respond on site to crises as follows: in urban areas, within one hour, and in rural areas, within two hours, as measured by the average annual response time.

Measures:

- In each year the Commonwealth has issued timely RFPs and selected a sufficient number of mobile crisis teams in each region to respond in the time period required
- The Mobile Crisis Team has developed its program and has sufficient staff capacity to respond in the time period required
- The Mobile crisis team receives crisis calls 24 hours a day 7 days a week and based upon need for in-home assessment or intervention deploys staff in the time period required

Methods: The Expert will review the issuance of RFPs and the selection process to ascertain timeliness and will review the selected providers' plans and implementation timeframes for the first review period (6/12). Data will be provided by each Region regarding the time in which the team responded to each request for in-home assistance for each calendar year starting with the second review period (1/13).

Settlement Decree Requirements:

iii. Crisis stabilization programs

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

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

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

Measures:

- The mobile crisis team has provided assessment, in-home support when appropriate and links to community resources before considering crisis stabilization programs
- The mobile crisis team has affiliations with community providers and has collaborated with them as appropriate to stabilize the individual's crisis situation
- A short-term community based placement is offered when appropriate to meet the individual's needs
- The case manager, family, individual, mobile crisis team, and provider collaborate to determine if an extended stay is necessary
- The length of stay in a short-term community –based placement is extended when needed by the individual and is suitable to meet the person's needs

Methods: The expert will review data provided by the region for all individuals served by the mobile crisis team who are referred for crisis stabilization: assessment determinations; use of community alternatives to the crisis stabilization programs; extensions of short-term out of home crisis stabilization stays, and documentation of provider affiliations.

Settlement Agreement Requirements:

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

E. With the exception of the Pathways Program operated by the Southwestern Training Center (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.

F. By June 30, 2012 the Commonwealth shall develop one crisis stabilization program in each Region.

G. 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.

Measures:

- The capacity of each crisis stabilization program does not exceed 6
- The length of stay does not exceed 30 days for any one individual
- Transitions are planned to return the person to his home or another community setting within 30 days to avoid hospitalization
- Each crisis stabilization program is located in a community setting

- Each region has at least 1 crisis stabilization program by 6/30/12
- The Commonwealth has a methodology to determine the number of crisis stabilization programs that are needed to meet the needs of individuals with ID or DD who requires out of home crisis stabilization
- Each region has developed the number of crisis stabilization programs determined to be needed by 6/30/13
- Each region has sufficient capacity to avoid unnecessary ER utilization or inpatient hospitalization

Methods: The expert will review the facility size and locations, data on the LOS for the reporting period, the Commonwealth's methodology for determining capacity and the number of facilities developed within the timeframes established by the Settlement Agreement, and the ER and hospitalization utilization for all individuals referred to the mobile crisis teams.

Proposed Evaluation Activities

Currently Virginia is in the planning stage of developing its crisis response system for individuals with ID and DD. An initial review is proposed to be completed by July 1, 2012 which will include the following:

- A review of Sections 6.a. i., ii. and iii. requirements as outlined under the initial review above
- A review of Sections 6.b.i.A and 6.b.i.B using the measures and methods outlined above
- A review of Sections 6.b.ii.F and 6.b.iii.F using the measures and methods outlined above

The work effort anticipated to accomplish this initial review is:

ACTIVITY	ESTIMATED HOURS	COST
Document review	18 hours	$3,200
Interviews with Program Directors and State Administrators	20 hours	$5,500
Report Writing	12 hours	$3,300
		Total cost: $12,000

The report will include findings, a summary of barriers to timely development of the crisis system and recommendations to address any barriers to the implementation of the settlement agreement requirements for crisis services.
The Independent Reviewer and Expert will discuss the timing of subsequent reviews and a cost proposal will be provided.