COMMONWEALTH of VIRGINIA

Office of the Inspector General

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November 30, 2010

To: Governor Robert F. McDonnell
The General Assembly of Virginia
The Joint Commission on Health Care

The Office of Inspector General (OIG) was established by the *Code of Virginia* § 37.2-423 to provide an independent system of accountability to the Governor, the General Assembly, service recipients and other interested parties for the services provided by the state operated facilities and the network of public and private providers licensed by the Department of Behavioral Health and Developmental Services (DBHDS).

We are pleased to submit this Semi-Annual Report for the period ending September 30, 2010 pursuant to § 37.2-425 of *The Code* that requires the OIG report periodically on its activities and outstanding recommendations, and to provide a description of significant systemic problems, abuses, and deficiencies.

During the past six months, the OIG has completed unannounced inspections at eleven (11) facilities operated by the DBHDS and three (3) investigations at state facilities. We are pleased to provide for your consideration a summary of these activities in this Semi-Annual Report.

Sincerely,

G. Douglas Bevelacqua
Inspector General

COMMONWEALTH of VIRGINIA

Office of the Governor

Robert F. McDonnell
Governor

November 30, 2010

General Assembly of Virginia
Capitol Square
Richmond, Virginia

Dear members of the General Assembly:

While serving in the General Assembly, I was the chief patron of legislation to restructure and move Virginia's behavioral health system to a community-based model, which most believe is the proper approach for Virginia. Upon taking office last January, I was troubled to learn that there are still problems in Virginia's system of behavioral health and developmental services that have remained unaddressed for many years, and involve operational issues at our state facilities and the insufficient capacity to serve those in need of community-based services. The Inspector General for Behavioral Health and Developmental Services, Doug Bevelacqua, outlines a number of these issues in his November 30, 2010 Semiannual Report. The report also includes a strategic plan developed by the Department of Behavioral Health and Developmental Services (DBHDS) entitled "Creating Opportunities: A Plan for Advancing Community Focused Services in Virginia." This plan provides a road map to correct many of the systemic issues with our system of care for citizens with mental illness, developmental disabilities and substance use problems.

During the past year, we have taken a number of actions to address concerns in the state facilities. New leadership has been brought in at Eastern State Hospital (ESH) where historical operational problems led to Medicaid decertification of the Hancock Geriatric Treatment Center, at Central Virginia Training Center (CVTC) where the Department of Justice (DOJ) has been conducting an investigation since 2008, and at the Virginia Center for Behavioral Rehabilitation (VCBR). Expert consultants have been engaged to work with staff at ESH and CVTC to assist in regaining Medicaid certification and prepare for our response to the anticipated DOJ findings. Commissioner Stewart, as a part of the DBHDS "Creating Opportunities Plan," has begun the development of a statewide quality review and improvement system for all state hospitals and training centers.

I know we will not immediately solve all of the problems detailed in the OIG's report, but it is critical that we begin to work on these issues without delay. Community programs providing intensive supports to those with serious mental illnesses permit those individuals to

successfully reside in the community. Younger families are no longer choosing to place their loved ones in training centers and often wait to receive MR/ID Medicaid waivers to enable integrated living in the community. Virginia must continue to expand the MR/ID Medicaid waivers as well as the capacity of community programs to ensure that all individuals with intellectual disabilities who are capable of living stable lives in the community are provided opportunities to receive care in their communities.

To further my commitment to reforming Virginia's system of behavioral health and developmental services, I will introduce budget amendments in the coming session of the General Assembly to provide a "down payment" toward solutions to these concerns. At this date, I am still working with our budget staff to determine which problems to address first, but I am committed to working with all interested parties to move Virginia's community-based system of care forward, as contemplated by my legislation almost a decade ago.

In closing, let me say that I believe we have already come a long way from a largely institutional system of services to one that is primarily community-based. Our network of public and private providers are working together effectively to provide quality services. We now need to close the gap by increasing the capacity of our community services in order to enable those with intellectual and developmental disabilities to live a more self determined life and to support those with mental illness on their journey of recovery. New treatment plans and pharmaceutical interventions now make this the best course of action for patients. I look forward to our work together in the coming session of the General Assembly to strengthen our behavioral health and developmental services in the Commonwealth.

Sincerely,

Robert F. McDonnell

RFM/jje

2010

OIG Semiannual Report

April 1, 2010 to September 30, 2010

Office of the Inspector General

Behavioral Health and Developmental Services

G. Douglas Bevelacqua
Inspector General
October 21, 2010

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Creating Opportunities: A Plan for Advancing Community-Focused Services in Virginia, June 25, 2010

FOREWORD

The *Mission* of the Office of the Inspector General is to provide an independent system of accountability to the Governor, the General Assembly, and the citizens of the Commonwealth for the quality of services provided by the Department of Behavioral Health and Developmental Services (DBHDS), and other licensed providers of behavioral health and developmental services, in order to protect the health and welfare of service beneficiaries.

The OIG's *Mission* is authorized by the *Code of Virginia* §§ 37.2-423, 37.2-424, & 37.2-425 that requires the Office to inspect, monitor, and review the quality of services in state facilities, and other licensed providers, and to make policy and operational recommendations in response to complaints of abuse, neglect or inadequate care.

To support its *Mission*, the OIG reports semi-annually to the Governor, the General Assembly, and the Joint Commission on Health Care concerning significant problems, abuses, and deficiencies relating to the programs and services of state facilities and other licensed providers.

The Code requires that the SAR identify "each significant recommendation, described in previous reports under this section, on which corrective action has not been completed." Inasmuch as the current Inspector General was appointed on May 1, 2010, it is appropriate, and required, to review previous SAR's and identify past significant recommend-dations that are still in-process. The results of this review are contained in the section of this SAR captioned *Significant Outstanding Findings and Recommendations from Past OIG Reports*.

The Code also requires that the SAR provide "A description of significant problems…during the reporting period" and, therefore, a discussion of the U. S. Department of Justice's (DOJ) activity in Virginia is contained in the section captioned *OIG Monitoring of the U. S. Department of Justice Involvement at Central Virginia Training Center.*

EXECUTIVE SUMMARY

The Commonwealth's system of behavioral health and developmental services has experienced both significant problems and opportunities in recent months, and the highlights of these are summarized below as required by § 37.2-424 and § 37.2-425 of *The Code*.

"CREATING OPPORTUNITIES: A PLAN FOR ADVANCING COMMUNITY-FOCUSED SERVICES IN VIRGINIA"

The *Creating Opportunities Plan* is likely the most consequential document created by the DBHDS in a generation. Commissioner Stewart and the State Board deserve accolades for the plan that will guide the Commonwealth's behavioral health and developmental services initiatives for the next three and a half years – and beyond.

The *Creating Opportunities Plan* fashions strategic initiatives and action steps to realize the Department's *Strategic Plan* vision of a community-focused system of care "that promotes self-determination, empowerment, recovery, resilience, health, and the highest possible level of participation by individuals receiving services in all aspects of community life." With its focus on person-centered community-based services, achieving the highest level of independence – while engaging in meaningful activities and participating fully in the community, this impressive *Plan* holds-out the promise of achieving Governor McDonnell's goal of creating a true Commonwealth of Opportunity for all Virginian's – including those served by the Department of Behavioral Health and Developmental Services. We have appended a copy of *The Creating Opportunities Plan* to this SAR for convenient reference.

THE DECERTIFICATION OF EASTERN STATE HOSPITAL'S HANCOCK GERIATRIC UNIT

Following repeat site inspections during the spring and summer, the Federal Center for Medicare and Medicaid Services (CMS) decertified Eastern State Hospital's (ESH) Hancock Geriatric Unit on September 12, 2010. Hancock Geriatric is a 150 bed geriatric facility on the campus of ESH in Williamsburg serving geriatric residents with a co-occurring behavioral health diagnosis.

The decertification means that ESH is ineligible to receive approximately $1.2 million monthly in Medicaid and Medicare payments until the Hancock Center is surveyed and deemed

an acceptable provider to deliver services. The DBHDS and ESH are working to prepare for a re-inspection, but as of October 21, 2010, they had not scheduled a follow-up inspection from CMS to reinstate Hancock's certification.

The Inspector General believes that Hancock's residents are well cared for; nevertheless, all residents, and/or their legal guardians, were officially notified of the decertification, and given the option of relocating to another facility. The OIG understands that all residents chose to remain at ESH.

THE INVESTIGATION OF CENTRAL VIRGINIA TRAINING CENTER BY THE U.S. DEPARTMENT OF JUSTICE

Since the fall of 2008, the United States Department of Justice (DOJ) has been actively investigating the Central Virginia Training Center (CVTC) and the Commonwealth's system of care for persons with developmental disabilities. Under the current DOJ leadership, the investigation has expanded and evolved, from a review of CVTC's compliance with the Civil Rights of Institutionalized Persons Act (CRIPA), into an examination of the state's training center system, and an evaluation of Virginia's community capacity measured against the requirements of the *Americans with Disabilities Act (ADA)* and the Supreme Court's *Olmstead Decision.*

If the DOJ follows the model it created in Arkansas this year, Virginia can expect a Federal complaint alleging that the Commonwealth has failed to transition people confined to training centers to the most integrated setting appropriate to their needs, and that the state has inadequate community services to serve its developmentally disabled residents. These themes have undergirded DOJ's *Olmstead* actions this summer against Arkansas, Georgia, New Jersey, Illinois, and Florida and are embedded in the *Amicus Curiae* brief DOJ filed in Federal Court in support of *The Arc of Virginia v. Timothy M. Kaine, et al.* (Civil Action No.: 3:09cv686). A summary of DOJ's findings at CVTC can be found on page 25 below.

CENTRAL STATE HOSPITAL HOMICIDE INVESTIGATION

The tragic alleged patient-on-patient homicide earlier this year at CSH highlights the danger inherent in co-mingling patients with serious mental illness (SMI) with persons undergoing court-ordered evaluation who may have personality disorders like psychopathology. The forensic population is the fastest growing segment of Virginia's

behavioral health system and a top priority of the OIG for the upcoming year is to study this aspect of the system and recommend changes that will improve both patient and staff safety. Most forensic patients are admitted pursuant to a court order authorized by *The Code* including evaluation of competency to stand trial, restoration of competency to stand trial, emergency treatment prior to trial, or after, sentencing, various NGRI petitions, and TDOs & ECOs.

EXCESSIVE OVERTIME INVESTIGATION

While overtime has been a systemic problem for several years in state facilities, this year overtime reached unprecedented levels at one state-operated facility. The OIG conducted an investigation of this facility's use of overtime and concluded that, by any reasonable standard, its reliance on overtime was excessive. This facility's unsustainable use of overtime, as opposed to employing a right-sized workforce, had a measureable and detrimental impact on resident care, employee retention and recruiting, and staff morale. The DBHDS has taken steps to correct the immediate problem at this facility and will presently issue clear instructions to establish overtime guidelines for the Commonwealth's state-run facilities.

ACTIVITIES OF THE OFFICE OF INSPECTOR GENERAL

Inspections, Investigations and Reviews Conducted by the OIG

The OIG is required by *Code* § 37.2-424.3 to conduct at least one unannounced visit annually at each of the fifteen state-operated behavioral health and developmental services facilities. Unannounced visits are conducted at a variety of times and across shifts. During this semi-annual reporting period, the office conducted 12 unannounced visits at the following facilities:

- Central State Hospital in Petersburg
- Eastern State Hospital in Williamsburg (Inspection)
- Central Virginia Training Center in Lynchburg
- Western State Hospital in Staunton
- Southern Virginia Mental Health Institute in Danville
- Northern Virginia Mental Health Institute in Falls Church
- Commonwealth Center for Children and Adolescents in Staunton
- Eastern State Hospital in Williamsburg (Investigation)
- Southwestern Virginia Mental Health Institute in Marion
- Piedmont Geriatric Hospital in Farmville
- Catawba Hospital in Catawba
- The Pine's Treatment Center (Crawford Campus) in Portsmouth

The OIG also conducted an announced follow-up review at Central Virginia Training Center during this period.

Summary of Reports Issued this Reporting Period

The OIG generates three types of reports: Inspections, Investigations, and Reviews. A brief description of each type of report created by the OIG follows:

INSPECTION REPORT: The purpose of an inspection by the OIG is to assess the quality of care provided by a facility or program. The focus may be on any aspect or service delivery, treatment, or operations. Inspections will normally include assessments related to some aspect of active treatment, staffing, and the service delivery environment. An inspection may be conducted to follow-up on progress made by a provider in response to earlier OIG findings and

recommendations. Inspection reports are routinely placed in the public domain, via the OIG's website, after the OIG has accepted the provider's response to findings and recommendations.

INVESTIGATION REPORT

INVESTIGATION REPORT: An investigation is conducted by the OIG in response to a specific incident, complaint, or event. The purpose of an investigation is generally to determine if abuse or neglect has occurred, inadequate quality of care has been provided, or a policy/procedure has been violated. The incident, complaint or event may come to the attention of the OIG through a variety of avenues: email, phone call or letter from an individual, a service provider, DBHDS, or any other source. An investigation most often, but not always, will involve a site visit to a facility or program. The investigation process may include: interviews with the complainant(s), service recipient, family members, provider staff and/or others, the review of policies/procedures and records, observations, and analysis or assessment of pertinent data. Each investigation will be documented in a report, and the report may include one or more findings and recommendations if the findings warrant specific actions by the provider, DBHDS or other parties. Investigation visits to providers can be announced or unannounced. Investigation reports will normally remain classified as "Confidential Governor's Working Papers" because they contain confidential information about service recipients, family members or provider staff.

REVIEW REPORT

REVIEW REPORT: A review by the OIG is a series of inspections that focus on the quality of care provided by a system of care. The system of care on which the review focuses may include all state facilities, all state facilities of a similar type (behavioral health hospitals or training centers), all community services boards (CSBs), a region of CSBs or providers, all providers (public and private) that serve a defined population, or any other combination that is identified by the OIG. Each review will be documented in a report, and the report may include one or more findings and recommendations if the findings warrant specific actions by the providers, DBHDS or other parties.

During the period covered by this SAR, the OIG completed four reports: one inspection and three investigations. These reports are cited below:

- OIG Report No.190-10, Eastern State Hospital Inspection.
- Three reports were completed on investigations that were conducted to investigate specific incidents or complaints at facilities operated by DBHDS, which are not published due to the confidential nature of incidents.

Findings and Recommendations from Reports Published During This SAR Reporting Period

OIG Report No. 190-10, Eastern State Hospital Unannounced Inspection

Finding No. 1: ESH's risk management program is not in compliance with DI 401. Most notably, the facility does not have a risk management plan that establishes the authority of the program.

Recommendation No. 1a: It is recommended that ESH create and implement a comprehensive risk management plan, which addresses the program's authority, visibility, accountability, communication, and coordination with all organizational functions, including abuse/neglect investigations.

Recommendation No. 1b: It is also recommended that the plan be submitted to the Central Office Risk and Liability Management/ Director to assure that the plan is consistent with the DBHDS Risk Management Plan, as required by DI 401.

Recommendation No. 1c: Upon the completion of the risk management plan, it is recommended that ESH provide competency based in-service training to all staff regarding the importance of, and their role in, assuring risk prevention and risk reduction.

Findings and Recommendations from Reports Published During This SAR Reporting Period

Finding No. 2: ESH does not have a current quality improvement plan that integrates risk prevention and risk monitoring activities.

Recommendation No. 2a: It is recommended that ESH create and implement a comprehensive quality improvement plan that addresses the program's authority, visibility, accountability, communication, and coordination with all organizational functions, including methods for integrating risk prevention and risk monitoring activities in quality improvement activities.

Recommendation No. 2b: Upon the completion of the quality improvement plan, it is recommended that ESH provide competency based in-service training to all staff regarding the importance of, and their role in, assuring quality care/ quality improvement.

Finding No. 3: There was significant variation in the thoroughness and consistency of detail of the information provided by staff on the incident report forms.

Recommendation No. 3a: It is recommended that the risk manager at ESH, in consultation with the Central Office Risk and Liability Director, prepare and conduct an in-service training for all staff regarding documenting events to assure that the reports are fact based, thorough, and identify the actions taken towards assuring the proper care and treatment of the individual.

Recommendation No. 3b: It is also recommended that DBHDS conduct a study of incident reporting in all the state-operated facilities to assure that information being provided by staff is thorough and consistent.

Finding No. 4: ESH does not adequately analyze and trend the event information currently collected to ensure that its services address all identified individualized areas of risk for its patients. Without accurate and comprehensive trending of incident data, including BAR (Baseline Analysis and Review)

Findings and Recommendations from Reports Published During This SAR Reporting Period

reviews, the facility cannot recognize emerging trends before potentially serious conditions arise.

Recommendation No. 4: It is recommended that ESH, with input from Central Office risk management and quality improvement specialists, develop a system for in-depth analysis and trending of aggregate event information in order to:

1) Inform clinical teams and administrative leaders of potential risks and,

2) Support the development of both individual and facility-wide risk reduction strategies. The thoroughness of clinical assessments, staffing patterns, and other factors, such as staff overtime, need to be assessed to assure that all potential and contributing risk issues are identified. Unit specific feedback is recommended so that staff can openly discuss the unit's strengths and areas for improvement in a non-threatening manner.

Finding No. 5: ESH does not have adequate risk management or quality improvement links to treatment planning to assure that the optimal levels of care are occurring. When the data collected through event reporting and other mechanisms does not inform the treatment planning process, persons served at the facility are exposed to needless risk.

Recommendation No. 5a: It is recommended that, in the development of the facility's risk management and quality improvement plans, responsibilities for the development and monitoring of clinical quality indicators that support effective treatment planning be clearly delineated.

Recommendation No. 5b: It is recommended that quality indicators be established that link nursing care plans to patient outcomes. Quality indicators that are designed to provide feedback on nursing risk assessments, plans of care, and post-incident review tools can provide valuable information regarding overall nursing functioning within each unit.

Findings and Recommendations from Reports Published During This SAR Reporting Period

Finding No. 6: Abuse and Neglect investigations are not analyzed collectively or from a systemic perspective. Failure to complete in-depth analysis of the investigations prohibits the discovery of patterns among the investigations that have broader implications for the staff, patients, and treatment environments.

Recommendation No. 6a: It is recommended that ESH develop a process for collecting and evaluating the aggregate data and the circumstances surrounding abuse and neglect events so that potential administrative issues are discovered and addressed.

Recommendation No. 6b: It is recommended that DBHDS consider a similar process at all the state-operated facilities to assure that all the factors relevant to effective risk and liability management are identified, tracked, and monitored until corrective actions are completed.

Finding No. 7: While many of the environmental risk factors identified by the DBHDS safety review team have been addressed, alternatives to the actual physical plant changes, which were reported by DBHDS to be cost prohibitive, have not been implemented as reported. Increased staff supervision and on-going risk assessment have not been consistently implemented to diminish the risks factors associated with suicide or other patient safety risks, such as falls and unexplained injuries.

Recommendation No. 7: It is recommended that ESH, in consultation with the DBHDS safety review team, review staffing patterns and the use of clinical risk assessments to assure consistent application of these methods in areas where environmental changes were determined to be too costly or impractical to address. The goal would be to determine whether the proposed alternatives are adequate in addressing patient safety issues and to make the necessary adjustments to increase patient safety.

Significant Outstanding Findings and Recommendations (From Past OIG Reports)

Section 37.2-425.A.3 of the Code of Virginia requires that the OIG identify in its Semi-Annual Report, each significant recommendation on which corrective action has not been completed. Not all reports generated by the OIG are classified as public documents; investigations that focus on the care of specific individuals and/or the actions of personnel are considered *Confidential Governor's Working Papers* and not placed in the public domain. Active findings from previous reports have been briefly summarized in this section in order to provide areas of general concern. This section includes a summary of significant recommendations that remain active as of September 30, 2010.

Summary of Outstanding Recommendations

Division of Behavioral Health Services

State Operated Facility System

RECRUITMENT AND RETENTION OF REGISTERED NURSES: Just as the recruitment and retention of qualified nursing personnel has been a national concern, it has been an issue for the state-operated facilities, most notably at Eastern State Hospital. ESH has experienced challenges with recruitment and retention at the facility since 2005. DBHDS has involved Central Office personnel in supporting the facility in addressing critical shortages. However, recruitment and retention problems have consistently resulted in the facility operating below previously defined staffing levels for registered nurses: one registered nurse assigned per unit per shift.

OIG follow-up interviews with facility personnel in 2010 demonstrated that inadequate staffing patterns continue to result in increased overtime and decreased staff morale, increased safety risks, and decreased quality services. In addition, outstanding environmental safety issues in the Hancock Geriatric Treatment Center are being addressed through joint efforts by DBHDS and the OIG.

VIRGINIA CENTER FOR BEHAVIORAL REHABILITATION: DBHDS operates a facility designed to provide treatment for sex offenders who, after evaluation, are judged to present a danger to themselves and/or others. Since it opened in 2003, the number of sex offenders receiving treatment has grown

significantly, as have the challenges faced by the facility in providing treatment for this, often controversial, population. There were 17 residents at the facility when it was first inspected by the OIG in 2003. The current census for this 300-bed facility is approximately 260. On average, the facility's current admission rate is 6 to 8 admissions a month.

Inspections by the OIG for the past three years have consistently documented concerns at the facility including, but not restricted to the following: limited treatment opportunities provided the residents; inadequate or untimely clinical assessments and treatment planning; failed programming initiatives; insufficient clinical integration of nursing and medical staff into the overall treatment provided; and inadequate staffing to assure safety and effective programming. Ongoing concerns resulted in the 2008 OIG recommendation that an advisory committee be established to provide consultative support to the facility's leadership team in making operational and programming decisions.

After the retirement of the facility's original Director, the facility's Acting Director identified a number of additional issues in operations and treatment, which resulted in a joint DBHDS and OIG review. Issues from that review are currently being addressed. In August 2010, DBHDS hired a permanent facility director to oversee previously identified operational and programmatic changes. The hiring of a new clinical director, and re-establishing links to the Central Office Coordinator for Sexually Violent Predators Services, has created an increased focus on balancing the necessary treatment and security components of this program. Ongoing monitoring of this program will be a priority of the OIG during the next reporting period.

FILING CHARGES AGAINST FACILITY PATIENTS: Following the investigation of a critical incident at one of the mental health facilities in August 2009, the OIG recommended the revision of Departmental Instruction #205 (RTS) 89 *Filing Charges Against Patients or Residents*. This DI, which has not been revised since 1989, governs procedures for when charges are placed against a person while s/he is being served in a

state-operated facility. A draft of the policy is being developed by DBHDS. The considerable delay in completing the revision of this DI speaks to the complexity of developing an instruction that considers the diverse special populations served by the Department.

ADULT FORENSIC SERVICES: Issues that impact the delivery of forensic services have been the focus of a number of investigations completed by the OIG regarding critical incidents in several mental health facilities. As one of the fastest growing populations being served by the behavioral health facility system to-date, with approximately 40% of the facility population receiving forensic services, procedures for addressing the active treatment needs for this population remains an important area of focus for DBHDS.

Outstanding recommendations that impact this population center on the inherent safety risks of mixing persons with a severe mental illness with individuals with a primary personality disorder. Violence within the forensic settings continues to be one of the foremost concerns identified by the OIG. Acts of peer-to-peer aggression occur in all the facilities, but are a primary area of concern at Central State Hospital. While the acts of violence in this setting primarily consist of minor physical altercations, the violence in this setting extended to the 2010 publicized homicide of one of the individuals served.

Of the 27 critical incidents that occurred at Central State Hospital between April 1, 2010 and September 30, 2010, 13 or 48% were related to acts of peer-to-peer aggression. In order to diminish the safety risks associated with the mixing of the forensic populations, the OIG recommended that options for expanding the use of outpatient assessment (e.g. jail-based) and evaluations be reviewed with the courts to allow for increased screening of defendants prior to inpatient treatment and that DBHDS explore establishing increased security measures for individuals referred by the courts for forensic evaluations.

JUVENILE FORENSIC SERVICES: As with the adult forensic population, the OIG has identified concerns with the mixing of the juvenile forensic population with children with a serious mental illness and/or intellectual disability.

Adolescents who are court-ordered for evaluation represented 11% of the facility's population during the most recent OIG inspection (2009). The OIG recommended that DBHDS review the current utilization of child and adolescent resources in the facility setting and redirect funding in order to provide secure specialized community based crisis stabilization services for children and adolescents. Many of these individuals could be evaluated in the detention center, or other settings in the community from which they came, if sufficient clinical expertise and funding for these services were available in the child's home community. Redirection of funds could provide appropriate clinical capacity to conduct juvenile forensic evaluations through the CSBs or regional teams. With the proposed closing the Commonwealth Center for Children and Adolescents during the past two legislative sessions, efforts at focusing on this issue have not been thoroughly addressed to date.

The use of seclusion and restraint with the children and adolescent population has been an area closely monitored by the OIG for several years. The use of prone restraint was eliminated at the facility as a result of a 2008 OIG recommendation. While progress has been made at the facility to address the cultural and programmatic changes needed to eliminate the use of seclusion and restraint within this setting, issues associated with these practices are still unresolved. Ongoing monitoring of facility utilization, staffing patterns, and the use of seclusion and restraint remain a priority for the OIG.

RECOVERY PRINCIPLES: Over the course of three years, the OIG monitored recovery initiatives in the adult behavioral health facilities. As a result of the initial review, the OIG recommended that all of the facilities develop recovery plans with at least annual updates of progress completed until December 2011. The OIG recommended that the recovery plan and the annual updates be posted on each facility's

Summary of Outstanding Recommendations

Division of Behavioral Health Services

website for increased transparency and accountability. While updated plans have been submitted to the OIG for review, when the OIG checked on 10/01/10, a number of facilities updated plans were not posted on the websites as recommended. In the 2008 and 2009 reviews by the OIG, it was recommended that DBHDS create a vehicle for measuring recovery initiatives in the facilities through staff training, consumer satisfaction surveys, and the increased use of peer counselors. A Recovery Workgroup was established to guide recovery initiatives both in the facilities and in the CSBs; however, the group did not meet regularly and system-wide efforts were discontinued. As an aspect of the Department's "Creating Opportunities" work plan, a committee has been re-established to address the issues identified and agreed upon by DBHDS in 2009, including the establishment of recovery principles and practices in programs and services provided by the CSBs. The OIG will monitor the work of this committee.

Summary of Outstanding Recommendations

Community Studies

Community Studies

EMERGENCY SERVICES: In 2005, the OIG reviewed access to and the quality of the emergency services provided by the CSBs for individuals experiencing a crisis in their home community. Several outstanding recommendations remain from that report, including the recommendation that DBHDS develop consistent expectations for all state hospitals regarding 1) admission of consumers when acute beds are not available in local community hospitals and 2) admissions procedures during weekday, evening and weekend hours. Of particular concern was the availability of timely and appropriate emergency admissions for persons with intellectual disabilities experiencing acute behavioral challenges. These concerns, while improved, have not been resolved.

In addition, the OIG recommended that DBHDS lead an initiative that will enable a sharing of psychiatric resources between state facilities and CSBs. The recommendation was intended to maximize the effectiveness of physicians already

in the public provider system and enhance the continuity and quality of care provided in facilities and in the community. After considerable facility resistance to this recommendation, efforts to address this were discontinued by DBHDS in 2009.

Additional recommendations that remain outstanding include: the development of a training curriculum that is competency based regarding the principles of recovery that is consistent across the service system, including the CSBs, state facilities and licensed private providers; that CSBs work with consumers to develop advance directives or crisis plans to identify consumer and family preferences, resources and requests that should be honored if the consumer experiences a crisis; and that CSBs, with the assistance of DBHDS, develop electronic record systems that are accessible to ESPs around the clock.

DBHDS has established a committee to address the delivery of emergency services across the state to assure timely and appropriate services is provided in the least restrictive setting and to resolve outstanding OIG recommendations. The OIG will monitor the work of this committee.

PERSON-CENTERED CASE MANAGEMENT: In 2006, the OIG conducted separate studies of CSB mental health case management and CSB substance abuse outpatient services. Among the outstanding recommendations from those reviews, the most significant one centers on the development of a "model service planning system and format that is person-centered, reflects the principles of recovery, and meets all regulatory requirements"[1].

In response to the OIG recommendation for case management services, DBHDS indicated its intent to establish a workgroup to address the overall service planning system as well as the more specific recommendations made by the OIG which included: the studying and establishing, if determined advisable, a caseload standard for CSB case managers; supporting the funding of caseload standards;

[1] Cited from OIG Report No. 128-06 and OIG Report No. 129-06

developing strategies for increasing outreach by case managers; and developing a curriculum for the certification of case managers across the CSB system. In its 2009 follow-up, the OIG was informed that the intended workgroup never was effectively established so consequently a number of the recommendations made by the OIG were never addressed. DBHDS has currently initiated a task force to examine these issues and advance case management services within the Commonwealth. The OIG will monitor the work of this group.

In response to the OIG recommendations for substance abuse services, DBHDS reported that the System Operations Team recommended that the Case Management Best Practices Workgroup be re-convened and adaptations to address the specific needs of the substance use population would be made at the completion of that workgroup's activity. As previously noted, this particular workgroup was not reestablished in any meaningful way so this recommendation for the substance abuse services report remains unresolved as of the 2009 OIG follow-up.

CRISIS STABILIZATION UNITS: In 2009, the OIG conducted a review of residential crisis stabilization units (CSU) operated or contracted by the CSBs.The report was issued in February 2010. All of the recommendations from that report remain active. Significant findings and/or recommendations from that report include the following: that DBHDS failed to establish clear expectations for missions, target populations, program criteria, or date requirements for the CSUs that received General Assembly funding from FY2006 to early FY2010; that each CSB that operates a CSU conduct a review, with stakeholder feedback, regarding the ways that real and perceived delays in prompt and timely admissions of persons in crisis can be reduced, including increased access to medical and psychiatric services in the evenings and weekends, and resolving delays in providing medications; and that crisis stabilization services to persons with co-occurring intellectual disorders are virtually non-existent.

State Operated Facility System

EXCESSIVE OVERTIME: The excessive use of overtime in one of the training centers operated by DBHDS was an area of recent focus by the OIG. The use of overtime raised concerns regarding resident and staff safety as well as the quality of the services provided. DBHDS is conducting an investigation into the circumstances surrounding this issue. Findings of the DBHDS investigation will be forwarded to the OIG for review and regular updates will be provided to the OIG until this issue is resolved. The results of this investigation are confidential and, as such, are not available for public disclosure.

DENTAL SERVICES: In August 2009, the OIG investigated concerns regarding the delivery of dental services for one of the state-operated training centers. Given the extent of risks to the residents revealed during this investigation, the OIG recommended that DBHDS develop guidelines for dental services across the facility system, to include a number of elements such as:

a. The scope of services to be provided;
b. Credentialing of service providers, including dental hygienists;
c. Expectations regarding assessment and treatment;
d. Expectations regarding the documentation of services, including informed consent;
e. Expectations regarding the role of dental services in the development of individualized habilitation plans;
f. The establishment of quality indicators based on Standards of Care which are monitored both at the facility level and departmental level; and,
g. Ongoing peer review process for chart audits.

The guidelines are in development, but DBHDS' completion of this guideline has been delayed because of the specificity required in defining dental practices in institutional settings.

Summary of Outstanding Recommendations

Division of Developmental Services

EQUIPMENT PROTOCOLS: Since 2006, four residents in DBHDS training centers have experienced unfortunate accidents associated with the mechanical failure of equipment. As a result, the OIG recommended that associated protocols, procedures, and training be reviewed at all facilities operated by DBHDS and provisions made to insure that caregivers personally and physically assure the comfort and safety needs required by residents. DBHDS is actively addressing this issue and draft protocols are being reviewed by the newly established Quality Management Steering Committee. All mechanical systems have been updated and systems safety checks established and routinely monitored.

TRAINING CENTER EMERGENCY SERVICES: Since 2007, the OIG has been concerned about the lack of clearly defined policies regarding the role of the training centers in providing emergency services to consumers with intellectual disabilities who demonstrate severe behavior management problems and consumers who are dually diagnosed with intellectual disabilities and severe mental illness. Each region has developed practice standards that focus on the coordination of admissions to the most appropriate facility setting, for persons with intellectual disabilities in crisis; however, DBHDS has not formalized these practices into admission protocols that state clearly what conditions are appropriate for emergency admission, which are not, and when it is appropriate for an individual with either of these conditions to be treated in alternate settings.

As with emergency admissions practices, the OIG has expressed concern since 2007 regarding the process for determining readiness for discharge for persons served in the state-operated training centers. Discharge readiness is inadequately defined, varies significantly among the facilities, and does not drive an active process by which the program staffs at the facilities determine when a person is ready for discharge. The current discharge process does not always support active engagement between the facility and the community in identifying and pursuing more integrated

Summary of Outstanding Recommendations

Division of Developmental Services

settings for the persons served. Without this active process, neither the person nor the authorized representative has the opportunity to participate in transition planning from an informed perspective.

Efforts among the training centers to actively educate family members and/or authorized representatives regarding community options are limited. This lack of education does not help to reduce family resistance to community placement, which is identified by facility staff as the biggest barrier to discharge planning.

DBHDS is in the process of completing the long delayed revisions to its admissions and discharge protocols. Active discharge planning has been expedited by the U.S. Department of Justice's (DOJ) recent focus on the state's *Olmstead* initiatives through its involvement at Central Virginia Training Center (CVTC). The OIG also recommended that DBHDS initiate a system-wide quality improvement process that creates a process for comprehensive assessment of the barriers to discharge and community support needs for each person in the facilities. DBHDS has selected to use the Supports Intensity Scale (SIS) as the standardized assessment tool within all the training centers. It is anticipated that this will be completed for all residents within the next two years. The OIG will continue to monitor DBHDS' compliance with *Olmstead* and other initiatives associated with the DOJ's investigation at CVTC.

Monitoring of the U.S. Department of Justice Involvement at CVTC (2008 – 2010)

By letter dated August 2008, the U. S. Department of Justice (DOJ) notified the Commonwealth of Virginia that it intended to investigate potential civil rights violations at Central Virginia Training Center (CVTC) in Lynchburg. The DOJ's 2008 letter stated, "We are obliged to determine whether there are systemic violations of the Constitution or laws of the United

Monitoring of the U.S. Department of Justice Involvement at CVTC (2008 – 2010)

States in the conditions at CVTC. Our investigation will focus on protection of residents from harm, and habilitation and treatment programming."[2]

The DOJ's staff attorneys and experts subsequently visited the Lynchburg facility to determine CVTC's compliance with Federal law. The first site investigation of this facility occurred on November 18-21, 2008 and focused primarily on potential violations of *The Civil Rights of Institutionalized Persons Act (CRIPA)*. According to the DOJ, *CRIPA* authorizes the United States Attorney General to conduct investigations and to initiate any consequent litigation relating to the conditions of confinement in state operated institutions. Under *CRIPA*, the DOJ investigates covered facilities to determine whether there is a pattern, or practice, of violation of federal rights of persons related to reasonable safety, (including freedom from unreasonable restraints), adequate medical and mental health care, and individualized habilitation and education (active treatment).[3]

The second DOJ site investigation took place on August 18-20, 2010 and, during this phase of the DOJ involvement at CVTC, the DOJ experts focused on both CVTC's and the DBHDS's system wide activities in response to the *ADA* and the Supreme Court's *Olmstead* decision. According to the Assistant Attorney General currently leading DOJ's Civil Rights Division, "**The full and fair enforcement of the *ADA* and its mandate to integrate individuals with disabilities is a major priority of the Civil Rights Division of the DOJ.** The ADA protects individuals with disabilities from

[2] According to DOJ, its, authority in this area is underpinned by the following statutes:

- *Civil Rights of Institutionalized Persons Act (CRIPA)* USC § 1997
- *Americans with Disabilities Act (ADA)* 42 USC § 12131
- *Individuals with Disabilities Education Act, (IDEA)* 20 USC § 400
- *Rehabilitation Act of 1974*, 29 USC § 794

[3] *CRIPA* defines the term 'institution' as "any facility or institution (A) which is owned, operated, or managed by, or provides services on behalf of any State or political subdivision of a State; and (B) which is for persons who are mentally ill, disabled, or retarded, or chronically ill or handicapped." All of Virginia's state-operated training centers meet this definition.

discrimination by public entities."[4] [Emphasis Supplied by OIG]

The OIG is actively monitoring the DBHDS' response to the DOJ review at CVTC and the facility's on-going efforts to address issues identified by the DOJ experts during their site visits. From the outset, the OIG has participated in the site reviews, monitored the facility's compliance with its action plan, participated in telephone conference calls between the facility, the department, and the DBHDS consultants and participated in the exit conferences.[5]

History of DOJ Activities in Virginia and Nationwide

In the 1990's, the DOJ investigated civil rights concerns at four DBHDS mental health facilities and one facility serving persons with intellectual disabilities – Northern Virginia Training Center (NVTC). These inspections led to a series of settlement agreements in which Virginia pledged to make certain improvements in care under DOJ supervision. The OIG was created in 1999, in part, to provide oversight of on-going compliance with the conditions outlined in the settlement agreements. In 2003, the DOJ dismissed its case against Western State Hospital in Staunton, ending a 13-year process of federal investigations of state mental health and mental retardation facilities (currently called behavioral health and developmental services facilities).

Since 2000, the DOJ has conducted investigations in at least 10 states, including most recently in Illinois, Georgia, Maryland, Texas, and Arkansas. Past DOJ investigations focused primarily on the conditions that existed in the state facilities; however, recently the DOJ has also included reviews of *where* services are provided - not simply *how* they are provided - by examining the states' processes for assuring the provision of services in the most integrated setting as a key component of its investigative process.

[4] *Briefs Filed in Florida, Illinois and New Jersey to Support the Supreme Court's Olmstead Decision*, News Release, U. S. Department of Justice, May 26, 2010 http://www.justice.gov/opa/pr/2010/may/25.

[5] Consistent with the national standard of practice, the DBHDS hired a team of consultants to "shadow" the DOJ investigators during their initial 2008 visit, and to assist the Department in preparing a plan of correction based on the preliminary areas of concern identified during the DOJ site reviews.

History of DOJ Activities in Virginia and Nationwide

The DOJ has voiced a commitment to assuring that persons served in institutional settings are provided with the care and treatment they deserve under the law by placing an emphasis on a state's response to the *Olmstead Decision*.[6] In upholding Title II of the ADA, the Supreme Court has held that "unjustified [institutional] isolation . . . is properly regarded as discrimination based on disability."[7] Specifically, the Court established that states are required to provide community-based services and supports for persons with developmental disabilities. This three-pronged litmus test on the road to community placement includes the following:

- The state's treatment professionals have determined that community placement is appropriate;
- The transfer is not opposed by the affected individual; and,
- The placement can be reasonably accommodated, taking into account the resources available to the state and the needs of others with disabilities.

The regulations promulgated pursuant to the *ADA* state that "A public entity shall administer services, programs, and activities in the most integrated setting appropriate to the needs of qualified individuals with disabilities" [28 CFR 35.130(d)]. These regulations define the most integrated setting as one that "enables individuals with disabilities to interact with non-disabled persons to the fullest extent possible" [28 CFR pt.35, App. A at 450].

The most recent DOJ investigation has included a systematic examination of facility utilization (admission and discharge), discharge planning, and the capacity of communities to provide equivalent levels of services for persons now served in facilities. During the August 2010 onsite DOJ Investigation

[6] Statement of Thomas E. Perez, Assistant Attorney General, Department of Justice / The Subcommittee on the Constitution, Civil Rights, and Civil Liberties Committee on the Judiciary; United States House of Representatives entitled "The Civil Rights Division of the Department of Justice" presented December 3, 2009

[7] *Olmstead v. L.C.*, 527 U.S. 581, 597, 600 (1999)

Areas of Concern Identified by DOJ Experts

at CVTC and in its request for document production this summer, the DOJ focused on these aspects of Virginia's service delivery systems for people with developmental and intellectual disabilities.

Areas of concern that were identified by the DOJ experts during the November 2008 site visit included the following:

A. Active Treatment

DOJ Standard of Care[8]**:** Active treatment includes, but is not limited to, individualized training, education, and skill acquisition programs developed and implemented by interdisciplinary teams with the person and their authorized representatives to promote the growth, development, and independence of the individual. Residents are constructively harmed if not provided adequate habilitation assessments and active intervention because they are not able to build skills for success in a more integrated environment. Residents should be learning skills and supports that they will need to pursue their personal goals and improve their quality of life.

At CVTC, the DOJ experts reported the following:

- Individual support plans (ISP) and interventions do not reflect person-centered approaches.
- Assessments do not focus on outcomes important for the individual and his/her life.
- Treatment planning is not guided by choice and preferences.
- Individual schedules reflect minimal amounts of meaningful activities
- Interdisciplinary team meetings are inefficient and not oriented toward meaningful outcomes for the persons served.

[8] The DOJ "Standard of Care" descriptors were extrapolated by the OIG from language in the DOJ Settlement Agreements with Texas (2008), Maryland (2009) and Illinois (2009).

B. Protection from Harm – Behavioral Services

DOJ Standard of Care: The purpose of active training is to enable the movement of individuals into the most integrated setting appropriate to their needs as required by *Olmstead*. 527 U.S. at 607. Generally accepted professional standards of care require that appropriate psychological interventions, such as behavior programs and individual support plans, be used to address significant behavior problems and enable residents to live in more integrated settings. Inadequate behavioral programming increases a person's risk, denying residents the right to reside in a safe environment.

At CVTC, the DOJ experts reported the following:

- The behavioral assessment process at CVTC is underdeveloped and largely inadequate.
- There exists an inordinately high use of restrictive interventions.
- The facility needs additional staff resources in behavioral services.
- Direct care staff are not sufficiently trained and monitored to assure reliable implementation of behavior support plans.

C. Protection from Harm – Psychiatric Services

DOJ Standard of Care: Constitutional[9] and professional standards dictate that psychotropic medications are prescribed consistent with a documented psychiatric diagnosis and empirically based evidence of the medications' efficacy. Moreover, psychiatric professionals should record empirically based evidence of the psychotropic

[9] The Supreme Court recognized that persons with developmental disabilities who reside in state-operated facilities have a "constitutionally protected liberty interest in safety". *Youngberg v. Romeo*, 457 U.S. at 318

medications' efficacy, along with all attempts to determine the minimum effective dose of the medication for the resident. Without this information, treating professionals are unable to conduct an adequate risk analysis to determine whether the medication's inherent side effects are outweighed by the efficacy of the drug. The inappropriate use of psychotropic medications may undercut the other care and treatment provided making it more difficult for the individual to move to a more integrated setting.

At CVTC, the DOJ experts identified:

- That there was some disconnect between diagnosis and therapeutic decisions.
- That the use of psychotropic medication was not consistent with generally accepted practice standards because there was excessive intra-class poly-pharmacy, specifically with regard to use typical and atypical antipsychotic medications.
- There was a problem with the long-term use of benzodiazepines in high doses.
- The facility lacked continuous quality improvement protocols to assess psychotropic medication usage.
- There was a lack of adequate coordination between psychology and psychiatry.

D. Quality Improvement and Risk Management

DOJ Standard of Care: Constitutional requirements[10] and generally accepted professional standards mandate that a facility develop and maintain an integrated comprehensive continuous quality improvement (CQI) program to monitor and ensure quality of care across all aspects of care and treatment, as well as an incident and risk management system that seeks to prevent incidents and requires appropriate corrective action when incidents do occur. An effective quality management program must incorporate

[10] *Youngberg v. Romeo,* 457 U.S. 307

adequate systems for data capture, retrieval, and statistical analysis to identify and track trends. The program should also include a process for monitoring the effectiveness of actions taken in response to issues that are discovered. Effective incident and risk management depends on: (1) accurate data collection and reporting; (2) thorough investigations; (3) identification of actual or potential risks of harm, including the tracking and trending of data; and (4) implementation and monitoring of effective corrective and/or preventive actions.

At CVTC, the DOJ experts reported the following:

- The Quality Assurance department is external to the day-to-day operations of the facility. The QA function is not integrated into the operation of the service planners and service providers. The principles of ongoing quality are not integrated into ongoing operations, as it is a "look behind" system.
- The QA system does not "close the loop" through monitoring.
- Incident management is a "response to harm" process and not "prevention from harm" process.

During the DOJ onsite visit in August 2010, the following areas of concern were identified:

A. Comprehensive Transition Planning

DOJ Standard of Care: Comprehensive transition planning is grounded in *Olmstead*'s requirement of placing the persons served in the most integrated setting consistent with their needs. Generally accepted professional standards and federal law require that the treatment of individuals with developmental disabilities be focused on the development of skills and abilities that aid those individuals in overcoming their personal barriers to living as independently as possible. Thus, a focus on helping individuals move to live successfully in more integrated settings should underlie *all aspects* of the care and treatment.

- At CVTC, the DOJ experts reported in 2010 that the transition to less restrictive settings is too slow, resulting in individuals not having timely opportunities to live and work in such settings. The DOJ experts reported that this is due in part to the persons' served not receiving the training in the skills necessary to permit them to move to more integrated settings.

OIG Data Monitoring

Critical Incident Reports

Documentation of critical incidents (CI) as defined by *The Code § 2.1-817503* is forwarded routinely to the OIG by the DBHDS operated state hospitals and training centers. During this semi-annual reporting period, 461 critical incidents related to injuries and other areas of risk were reported to the OIG through the PAIRS database. Of these incidents, 234 (51%) incidents occurred in the state-operated training centers and 227 (49%) occurred in the state-operated behavioral health facilities. The OIG reviewed each of the 461 critical incident reports forwarded by DBHDS with an additional level of inquiry and follow up conducted on 98, or 21% of the CIs.

Quantitative Data

In order to refine the inspection process so that core risks could be monitored, a monthly facility report was instituted by the OIG. This report provides raw data on trends within facilities that might indicate a need for further clarification and onsite attention. Areas that are monitored through this monthly report include census, staffing vacancies and overtime use, staff injuries, and complaints regarding abuse and neglect. The office used this data to process clarification requests during this six-month reporting period as data elements in three of its investigations.

OIG Data Monitoring

Monitoring of Deaths

The OIG receives reports from the Medical Examiner's office for all of the deaths that occur in the state operated facilities. The OIG reviews each of the autopsy reports with the participation of a physician consultant. There were 49 deaths in the state-operated facilities from 4/1/10 to 9/30/10; 21 of the deaths occurred in the training centers and 28 deaths were reported in the behavioral health facilities. All of the 28 autopsies forwarded by the Medical Examiner's office for this period were reviewed.

Complaints and Requests for Information/Referrals

The OIG responded to 20 complaints and requests for information/referrals from citizens, service recipients, and employees. Of these contacts, 13 were complaints/concerns and 7 were requests for information/referrals.

Review of Regulations, Policies and Plans

During this semiannual reporting period, the OIG reviewed and/or made comments on the following regulations, polices and plans:

- DBHDS State Board Policy 2012(FIN) 86-1, Behavioral Health and Developmental Services Budget Priorities
- DBHDS State Board Policy 4023(CSB) 86-24, Residential Services
- DBHDS State Board Policy 5010(FAC) 00-1, State Facility Uniform Clinical and Operational Policies and Procedures
- DBHDS DI 803(ADM) 93, Central Office Grant Development Process and Commitment of Resources to Pursue or Support Grant Proposals
- DBHDS DI 214(RTS) 10, Use of Seclusion and Restraint in State Facilities
- DBHDS DI 215(RTS) 10, Use of Restraint for Secure Transport

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Other Activities

The OIG engages in a number of other activities, such as making presentations and serving on committees. Engagement in these activities results in increased knowledge of the system and allow for interaction of the OIG with state-level stakeholders. The following activities occurred during this semi-annual reporting period:

A. OIG staff made 6 presentations regarding the work of the office or served as the guest speaker;

- KOVAR Institute
- National Alliance on Mental Illness (NAMI)
- VOCAL state convention
- DBHDS Expert Input Panel on Children's Behavioral Health Services
- The Advisory Consortium for Intellectual and Developmental Disabilities
- Virginia Department of Social Services

B. Staff of the OIG participated in the two conference and training events;

- Reinventing Quality 2010 Conference
- Seclusion and Restraint Training with National Association of State Health Program Directors

C. The OIG participated in a variety of forums and on various committees that address issues relevant to mental health, intellectual disabilities and substance abuse and to state government;

- DBHDS Clinical Services Quality Management Committee
- DBHDS Systems Leadership Council
- Children's Mental Health Forum
- Supreme Court Commission on Mental Health Law Reform

Other Activities

D. The OIG staff met with the following agencies, organizations and other groups to seek input to the design of specific OIG projects;

- DBHDS central office staff
- DBHDS facility staff
- Service recipients and family members
- DOJ staff, DBHDS staff, and DBHDS consultants

This concludes the Semi-Annual Report of the Inspector General required by *The Code* § 37.2-425 covering the period April 1, 2010 to September 30, 2010.

If additional information about the contents of this *Report* is required, please direct inquiries to the below address, call (804) 692-0276, or fax questions to (804) 786-3400.

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Appendix

Creating Opportunities:

A Plan for Advancing Community-Focused Services in Virginia

June 25, 2010

CREATING OPPORTUNITIES: A PLAN FOR ADVANCING COMMUNITY-FOCUSED SERVICES IN VIRGINIA

Virginia Department of Behavioral Health and Developmental Services

June 25, 2010

CREATING OPPORTUNITIES: A PLAN FOR ADVANCING COMMUNITY-FOCUSED SERVICES IN VIRGINIA

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CREATING OPPORTUNITIES: A PLAN FOR ADVANCING COMMUNITY-FOCUSED SERVICES IN VIRGINIA

EXECUTIVE SUMMARY

To fulfill its responsibility to establish a strategic agenda and related initiatives for Virginia's behavioral health and developmental services system, the Department of Behavioral Health and Developmental Services (DBHDS) has developed *Creating Opportunities: A Plan for Advancing Community-Focused Services in Virginia*. The plan identifies behavioral health and developmental services strategic initiatives and major DBHDS activities to be addressed over the next three and a half years. These initiatives and activities are intended to:

- Continue progress in advancing the DBHDS vision of a system of behavioral health and developmental services and supports that promotes self-determination, empowerment, recovery, resilience, health, and the highest possible level of participation by individuals receiving services in all aspects of community life;
- Support the Governor's expressed intentions to achieve a Commonwealth of Opportunity for all Virginians, including individuals receiving behavioral health or developmental services; and
- Assure that the services system is efficient and well-managed and that its core functions are performed in a manner that is effective and responsive to the needs of individuals receiving services and their families.

The Creating Opportunities Plan, which was presented to and endorsed by the State Board of Behavioral Health and Developmental Services on June 25, 2010, is built on previous planning efforts; enabling the DBHDS to structure an accelerated and condensed planning process that will allow implementation of the following initiatives to begin quickly. For each strategic initiative, an implementation action team will be established to develop detailed implementation plans that will include specific action steps, outcomes, and timelines. The DBHDS and System Leadership Council will monitor the implementation of each initiative.

Behavioral Health Services Strategic Initiatives

1. Strengthen the responsiveness of the emergency response system and maximize the consistency, availability, and accessibility of services for individuals in crisis across Virginia.
2. Develop infrastructure to increase peers in direct service roles and expand recovery support services.
3. Address housing needs for individuals with mental health or substance use disorders through involvement in the Governor's initiative to reduce homelessness and expand affordable housing.
4. Create employment opportunities for individuals with mental health or substance use disorders through coordination with the Governor's Economic Development and Job Creation Commission.
5. Enhance access to a consistent array of substance abuse treatment services across Virginia.
6. Review and develop strategies to enhance the effectiveness and efficiency of state hospital services.

7. Strengthen the capability of the case management system to support individuals with long term mental health or substance use disorders and children with serious emotional disturbance.
8. Develop and implement a comprehensive plan for child and adolescent mental health services.

Developmental Services Strategic Initiatives

1. Build community services and supports capacity that will enable individuals who need developmental services and supports, including those with multiple disabilities, to live a life that is fully integrated in the community.
2. Address housing needs of individuals receiving developmental services and supports through involvement in the Governor's initiative to reduce homelessness and expand affordable housing.
3. Create employment opportunities for individuals receiving developmental services and supports through coordination with the Governor's Economic Development and Job Creation Commission.
4. Provide leadership and participate in interagency planning currently underway to identify responsibility at the state level for coordinating and providing services to individuals with development disabilities including autism spectrum disorders.
5. Strengthen the capability of the case management and support coordination system to support individuals receiving developmental services and supports.

DBHDS Major Activities:

In addition to implementing the above behavioral health and developmental services initiatives, DBHDS will be engaged in the following major activities:

1. Participate in the work of the Secretary of Health and Human Resources' Office of Health Care Reform and develop strategies to strengthen collaboration between the preventive and primary health care and the behavioral health and developmental services systems;
2. Address sexually violent predator (SVP) service capacity issues, including obtaining necessary resources to safely operate the Virginia Center for Behavioral Rehabilitation and provide appropriate SVP rehabilitation and treatment services; and
3. Develop information technology initiatives to implement electronic health records (EHR) and health information exchange (HIE) with state facilities, CSBs, other pertinent healthcare and provider agencies, facilitate quality management, and perform quality management and outcomes oversight.

In conclusion, the Creating Opportunities Plan affirms the DBHDS vision and builds on the foundation established in previous planning efforts, including the Integrated Strategic Plan. Successful implementation of these initiatives and major activities will continue progress toward achieving a community-focused system of behavioral health and developmental services and supports that increases opportunities for and enriches the lives of individuals receiving services.

CREATING OPPORTUNITIES: A PLAN FOR ADVANCING COMMUNITY-FOCUSED SERVICES IN VIRGINIA

I. Introduction

A. Purpose

To fulfill its responsibility to establish a strategic agenda and related initiatives for Virginia's behavioral health and developmental services system, the Department of Behavioral Health and Developmental Services (DBHDS) has developed *Creating Opportunities: A Plan for Advancing Community-Focused Services in Virginia.* This plan identifies behavioral health and developmental services strategic initiatives and major DBHDS activities to be addressed over the next three and a half years to:

- Continue progress in advancing the DBHDS vision of system of services and supports that promotes self-determination, empowerment, recovery, resilience, health, and the highest possible level of participation in all aspects of community life for individuals with mental health or substance use disorders or intellectual disability; and
- Support the Governor's expressed intention to achieve a Commonwealth of Opportunity for all Virginians, including individuals receiving behavioral health or developmental services; and
- Assure that the services system is efficient and well-managed and that its core functions are performed in a manner that is effective and responsive to the needs of individuals receiving services and their families.

Because the DBHDS and services system stakeholders have been planning together for years, there was no need to spend months rearticulating strategic directions that continue to have broad-based support. The Creating Opportunities plan is built on previous planning efforts, allowing the DBHDS to structure an accelerated and condensed planning process so that implementation can begin quickly. Completing the plan process by June 2010 will enable DBHDS to:

- Communicate its strategic agenda and priority initiatives to the Administration, General Assembly, individuals receiving services and their families, public and private providers, advocates, and other interested stakeholders;
- Focus DBHDS resources on implementing targeted initiatives and activities that advance community-focused services in Virginia; and
- Develop initiative proposals in collaboration with key services system stakeholders for consideration during the biennium budget development process.

B. Plan Development Process

The DBHDS set the framework for the Creating Opportunities planning process in February 2010, by identifying accomplishments, mandates, system change recommendations, and challenges and opportunities for behavioral health services and developmental services strategic actions.

In March, the DBHDS briefed the System Leadership Council on the Creating Opportunities planning process. The System Leadership Council, which includes representatives of community services boards (CSBs), state facilities, local governments, local hospitals, private providers, individuals receiving services and family members, advocacy organizations, regional jails, the State Board of Behavioral Health and Developmental Services, the Inspector General, and Department of Medical Assistance Services (DMAS), is uniquely positioned to provide consultation and feedback to the DBHDS as strategic initiative proposals for behavioral health services and developmental services were developed.

The Creating Opportunities planning effort used separate processes for behavioral health services and developmental services. The DBHDS established two planning teams, one for behavioral health services and the second for developmental services. Each team was comprised of individuals whose involvement with the services system as advocates, individuals receiving services and family members, public and private services providers, and state health and human resources agency staff offered perspectives, expertise, and experiences that enriched the process of identifying priority directions for the services system. Each team's membership is listed in Appendix A. The teams met three times, twice in April and once in May, to identify services system core functions and services and supports gaps; review services system effectiveness, efficiency, and enhancement opportunities; and recommend possible strategic initiatives and implementation actions to the DBHDS. The DBHDS considered these recommendations in its selection of strategic initiatives and identification of focus areas for each initiative's implementation. The Creating Opportunities plan was presented to and endorsed by the State Board of Behavioral Health and Developmental Services on June 25, 2010.

For each selected strategic initiative, an implementation action team will be established to work with the DBHDS over the next several months to develop detailed implementation plans that will include:

- Assignments of responsible parties to assure implementation happens;
- Detailed action steps with timelines;
- Organizations and individuals that will be involved in implementation;
- Performance outcomes with timelines and milestones required to monitor implementation.

Specific implementation actions recommended by the behavioral health services and developmental services planning teams will be provided to the applicable implementation action team for its consideration as it develops detailed action steps. The DBHDS and System Leadership Council will monitor the implementation of each initiative.

II. Commitment to Advancing Community-Focused Services

A. Building on the Foundation Established in the Integrated Strategic Plan

In 2006, the then Department of Mental Health, Mental Retardation and Substance Abuse Services adopted *Envision the Possibilities: An Integrated Strategic Plan for Virginia's Mental Health, Mental Retardation, and Substance Abuse Services System* (ISP) to provide a strategic blueprint for transforming Virginia's publicly-funded services system. The ISP includes values, critical success factors, and implementation action steps that are essential building blocks for the realization of the vision of a "consumer-driven system of services and supports that promotes self-determination, empowerment, recovery, resilience, health, and the highest possible level of consumer participation in all aspects of community life including work, school, family and other meaningful relationships" (State Board Policy 1036 (SYS) 05-3).

The ISP affirms that individuals with mental health or substance use disorders or intellectual disability are members of the community in which they live and should enjoy the same opportunities for quality of life. The overarching goal of the services system is to provide or assist individuals in obtaining services and supports based on informed choice that would enable them to

- Attain their highest achievable level of health and wellness;
- Live as independently as possible, with children living with their families;
- Engage in meaningful activities, including school attendance or work in jobs that they have chosen; and
- Participate in community, social, recreational, and educational activities.

The ISP includes values for the design and operation of the behavioral health and developmental services system that provide the foundation for this plan:

- Services and supports are person-centered, with the specific needs of each individual at the center of service planning and care coordination. Regardless of where an individual or family lives in Virginia, there is access to a broad array of services and supports that promote independence and enable individuals to live in their own homes wherever possible. Services and supports are flexible, allow for the greatest amount of individual choice possible, and provide an array of acceptable options to meet a range of individual needs.
- A consistent minimum level of services and supports is available across the system, with timely access to needed services. Services and supports are available and delivered as close as possible to the individual's home community in the least restrictive setting possible, are culturally and age sensitive and appropriate, and are fully integrated and coordinated with other community services. Services are universally and equally accessible regardless of the individual's payment source.
- The services system is designed to intervene early to minimize crises through early screening and assessment, appropriate interventions that keep individuals receiving services connected to their families and natural supports, and seamless access to services. Prevention, early intervention, and family support services are critical components of the services system. Crisis access and response is available 24 hours per day and seven days a week.
- Funding follows the individual to the extent possible and not a specific provider or service. Integrated funding reduces complexity and provides flexibility to create choices among services and supports that address an individual's unique needs.
- Adults and children requiring services and supports from multiple agencies are provided care that is coordinated across agencies.
- Services are of the highest possible quality and are based upon best and promising practices where they exist. Emphasis is placed on continuous quality improvement, workforce training and development, and use of technologies that promote efficiency and cost effectiveness at the provider and system levels.

B. Achieving the Promise of a Commonwealth of Opportunity

In his Inaugural and State of the Commonwealth addresses, Governor McDonnell pledged to create "A Commonwealth of Opportunity" for all Virginians. For individuals with mental health or substance use disorders or intellectual disability, achieving the promise of the Commonwealth of Opportunity means that they are able to live full and productive lives. For the behavioral health and developmental services system this means:

- Promoting the creation or expansion of opportunities for individuals receiving services to live full and productive lives by overcoming stigma and misperceptions regarding their abilities;
- Providing an array of community-focused services and supports that are person-centered, support recovery and self-determination, and prevent or reduce the use of more intensive interventions such as hospitalization or public safety involvement;
- Assuring case management and care coordination practices support creation and expansion of opportunities for individuals; and
- Establishing clear outcome expectations for stable housing and employment.

C. Identifying and Implementing Services System Efficiencies

A priority initiative for the Administration is finding new ways to deliver government services more efficiently and effectively. The strategic agenda for the behavioral health and developmental services system must challenge current thinking about how services are delivered and funded and pursue opportunities to realize savings. Potential efficiency and effectiveness enhancements include:

- Reducing unnecessary variability in the availability of service across Virginia;
- Breaking down or reducing funding silos and examining opportunities to leverage and realign funding to correspond to what people need to live their lives productively;
- Improving assessment and matching of services and supports to the needs of individuals to ensure only the needed level of the most appropriate services is provided;
- Pursuing opportunities to achieve economies of scale through regional services and supports and consolidated workforce development and training activities where appropriate;
- Simplifying record keeping and reporting requirements and assuring that requirements provide added value for costs incurred;
- Assuring that regulatory requirements are consistent wherever possible within (e.g., DBHDS licensing and human rights) and across (e.g., DBHDS licensing and Medicaid) agencies; and
- Enhancing partnership opportunities to address employment, housing, and transportation needs and access aging, social services, health, and early childhood resources.

III. Behavioral Health Services and Supports

A. Individualized Services and Supports for Identified Populations

A core function of the behavioral health services system is providing individualized services and supports that are tailored to meet the particular needs of individuals in the following groups:

- Persons of all ages with mental health or substance abuse problems or co-occurring mental health and substance use disorders who are in severe distress or crisis, at risk of causing or suffering serious harm, or at risk of arrest and who need urgent or emergency services;
- Adults, including older adults, with serious mental illness or adults, including older adults, with co-occurring mental health and substance use disorders who need long-term treatment, rehabilitative services, and related supports to promote recovery;
- Adults, including older adults, with substance use disorders, including substance abuse and dependence, who need long-term treatment and related supports to promote recovery; and
- Children and adolescents who have mental health or substance use problems or co-occurring mental health and substance use disorders who are at risk of involvement or are being served in the juvenile justice system or other out-of-home placement, who are at risk of being or have been expelled from school, or who require long-term community mental health or substance abuse treatment and other supports.

Behavioral health services and supports that are needed by these individuals are listed in Appendix B.

B. Behavioral Health Services Strategic Initiatives

Strategic initiatives selected by the DBHDS from recommendations provided by the Behavioral Health Services Planning Team follow.

1. STRENGTHEN THE RESPONSIVENESS OF THE EMERGENCY RESPONSE SYSTEM AND MAXIMIZE THE CONSISTENCY, AVAILABILITY, AND ACCESSIBILITY OF SERVICES FOR INDIVIDUALS IN CRISIS ACROSS VIRGINIA.

   Implementation Focus Areas

   - Align funding incentives that support desired emergency response outcomes, including increased voluntary treatment, reduction of restraint or treatment over objection, more in-home interventions, reduction of hospitalization, and diversion from police or criminal justice contact.
   - Involve the Virginia Hospital and Healthcare Association, state hospitals, CSBs, and local hospitals in discussions regarding the future need for inpatient psychiatric services and the roles of public and private hospitals in meeting the needs of individuals, including those with forensic involvement, who require acute or intermediate inpatient care.
   - Minimize use of the most intensive interventions through improved management of state hospital and local inpatient purchase of services (LIPOS) resources statewide.
   - Pursue opportunities to increase access to an adequate and more consistent continuum of emergency, crisis response, and jail diversion services across Virginia, including crisis stabilization and local reception or drop-off centers.

2. DEVELOP INFRASTRUCTURE TO INCREASE PEERS IN DIRECT SERVICE ROLES AND EXPAND RECOVERY SUPPORT SERVICES.

   Implementation Focus Areas

   - Implement a wide range of peer-provided services and supports through hiring peers in various roles, including peer support, at CSBs, in state and private facilities, and through contracts with independent peer-provided service programs.
   - Address funding and administrative barriers to peer-provided services and supports.
   - Develop and implement a peer specialist training program in the Commonwealth.
   - Establish peer support as a discrete Medicaid service.

3. ADDRESS HOUSING NEEDS FOR INDIVIDUALS WITH MENTAL HEALTH OR SUBSTANCE USE DISORDERS THROUGH INVOLVEMENT IN THE GOVERNOR'S INITIATIVE TO REDUCE HOMELESSNESS AND EXPAND AFFORDABLE HOUSING.

   Implementation Focus Areas

   - Participate with the Governor's Senior Economic Advisor, the Secretary of Commerce and Trade, the Director of the Department of Housing and Community Development (DHCD), the Executive Director of the Virginia Housing Development Authority (VHDA), and other Secretariats and agencies to implement the housing policy established in Executive Order 10 (2010) and create a range of housing opportunities for individuals with mental health, substance use, or co-occurring disorders.
   - Establish clear outcome expectations for stable housing to include specific goals and state and local strategies for leveraging housing resources for individuals receiving publicly-funded behavioral health services.

- Communicate the updated State Board of Behavioral Health and Developmental Services Policy 4023 (CSB) 86-24 Housing Supports to affected stakeholders. This policy encourages CSBs to assist individuals whom they serve to obtain or retain housing in their home communities within resources available and to expand partnerships and work collaboratively with federal and state housing agencies. The updated policy will be considered for adoption by the State Board in September 2010. (This language was altered on July 2, 2010 to more accurately reflect the status of the proposed State Board policy.)
- Survey CSBs about resources they spend solely on providing housing, including rent subsidies, that might be reprogrammed for treatment services if other housing resources could be accessed.

4. CREATE EMPLOYMENT OPPORTUNITIES FOR INDIVIDUALS WITH MENTAL HEALTH OR SUBSTANCE USE DISORDERS THROUGH COORDINATION WITH THE GOVERNOR'S ECONOMIC DEVELOPMENT AND JOB CREATION COMMISSION.

Implementation Focus Areas

- Coordinate with the Governor's Economic Development and Job Creation Commission established under Executive Order 1 (2010) to create economic and workforce development and job creation opportunities for individuals with mental health, substance use, or co-occurring disorders.
- Establish clear outcome expectations for employment to include specific goals and state and local strategies for addressing barriers to employment experienced by individuals receiving CSB behavioral health services.
- Develop employment services and supports strategies in partnership with the Department of Rehabilitative Services (DRS) and DMAS that are specifically designed to meet the needs of individuals with mental health, substance use, or co-occurring disorders.
- Realign the orientation of day support services to focus on establishing and sustaining real work opportunities for individuals with mental health, substance use, or co-occurring disorders.

5. ENHANCE ACCESS TO A CONSISTENT ARRAY OF SUBSTANCE ABUSE TREATMENT SERVICES ACROSS VIRGINIA.

Implementation Focus Areas

- Assess and identify gaps in the array of evidence-based substance abuse treatment services and develop proposals for addressing them.
- Assess the extent to which CSBs have the capability to provide integrated substance abuse and mental health assessment and treatment for individuals with co-occurring mental health and substance use disorders and provide technical assistance and training to enhance that capability.
- Expand partnerships with the criminal justice system to include substance abuse treatment in jails and in re-entry programs for offenders.

6. REVIEW AND DEVELOP STRATEGIES TO ENHANCE THE EFFECTIVENESS AND EFFICIENCY OF STATE HOSPITAL SERVICES.

Implementation Focus Areas

- Develop an annual internal administrative and programmatic review and audit process; and
- Review and recommend enhancements in state hospital quality improvement activities.

7. STRENGTHEN THE CAPABILITY OF THE CASE MANAGEMENT SYSTEM TO SUPPORT INDIVIDUALS WITH LONG TERM MENTAL HEALTH OR SUBSTANCE USE DISORDERS AND CHILDREN WITH SERIOUS EMOTIONAL DISTURBANCE.

Implementation Focus Area

- Implement the recommendations of the case management and support coordination capacity workgroup.

8. DEVELOP AND IMPLEMENT A COMPREHENSIVE PLAN FOR CHILD AND ADOLESCENT MENTAL HEALTH SERVICES.

Implementation Focus Area

- Implement the recommendations of the comprehensive plan for child and adolescent mental health services required by Item 304.M of the 2010 Appropriation Act.

IV. Developmental Services and Supports

A. Individualized Services and Supports for Identified Populations

A core function of the developmental services system is providing individualized services and supports that are tailored to meet the particular needs of individuals in the following groups:

1. Individuals with intellectual disability, which originates before the age of 18 years and is characterized concurrently by (i) significantly subaverage intellectual functioning as demonstrated by performance on a standardized measure of intellectual functioning, administered in conformity with accepted professional practice, that is at least two standard deviations below the mean and (ii) significant limitations in adaptive behavior as expressed in conceptual, social, and practical adaptive skills (Code of Virginia definition). This includes individuals who may have one or a combination of the following conditions:
   a. Individuals whose level of intellectual disability is so severe that they require extensive supports;
   b. Individuals who are medically fragile or have one or more chronic physical health or sensory conditions;
   c. Individuals who have behavioral challenges, including involvement in the criminal justice system or a co-occurring disorder or disability such as a mental illness or autism spectrum disorder;
   d. Individuals with specialized supports needs related to their age, i.e., older adults; or
   e. Individuals who need intermittent or limited supports or assistance.
2. Infants and toddlers, from birth to three years of age, who have been diagnosed with developmental delay, atypical development, or a physical or mental condition that has a high probability of resulting in developmental delay.

Developmental health services and supports that are needed by these individuals are listed in Appendix B.

B. Developmental Services Strategic Initiatives

Strategic initiatives selected by the DBHDS from recommendations provided by the Developmental Services Planning Team follow.

1. BUILD COMMUNITY SERVICES AND SUPPORTS CAPACITY THAT WILL ENABLE INDIVIDUALS WHO NEED DEVELOPMENTAL SERVICES AND SUPPORTS, INCLUDING THOSE WITH MULTIPLE DISABILITIES, TO LIVE A LIFE THAT IS FULLY INTEGRATED IN THE COMMUNITY.

Implementation Focus Areas

- Improve and expand Medicaid waiver services and supports.
  - Improve and expand current intellectual disability (ID) waiver services and supports capacity; and
  - Develop a plan and timeframe for redesigning the current ID and developmental disability (DD) waivers.
- Provide services and supports for individuals who need intermittent or limited supports but are not eligible for waiver services.
  - Develop a budget initiative to expand services system capacity to provide flexible supports for families and transition services; and
  - Enhance linkages with the Department of Education to improve the transition process for individuals and families.
- Provide access to dental, health, and behavioral supports and other specialized services and supports in communities where individuals live.
  - Develop a comprehensive emergency response system of services;
  - Enhance partnerships to access aging, social services, health, and early childhood services and resources; and
  - Develop a mechanism for providers to pool resources regionally to access specialized services.
- Develop avenues to assist individuals in training centers transition to appropriate settings through investments in community supports and prudent investment in infrastructure.
  - Respond to recommendations of the U.S. Department of Justice; and
  - Implement the Southeastern Virginia Training Center (SEVTC) and Central Virginia Training Center (CVTC) downsizing projects.

2. ADDRESS HOUSING NEEDS OF INDIVIDUALS RECEIVING DEVELOPMENTAL SERVICES AND SUPPORTS THROUGH INVOLVEMENT IN THE GOVERNOR'S INITIATIVE TO REDUCE HOMELESSNESS AND EXPAND AFFORDABLE HOUSING.

Implementation Focus Areas

- Participate with the Governor's Senior Economic Advisor, the Secretary of Commerce and Trade, the Director of DHCD, the Executive Director of the VHDA, and other Secretariats and agencies to implement housing policy established in Executive Order 10 (2010) and create a range of housing opportunities for individuals receiving developmental services and supports.
- Communicate the updated State Board of Behavioral Health and Developmental Services Policy 4023 (CSB) 86-24 Housing Supports to affected stakeholders when it is adopted by the State Board in September. (This language was altered on July 2, 2010 to more accurately reflect the status of the proposed State Board policy.)
- Develop housing options that are separate or decoupled from provision of traditional residential services and provide greater mobility and flexibility for individuals. [Housing Study (2009)]
- Participate with the VHDA, DHCD, and Virginia Board for People with Disabilities (VBPD) in the development of a state housing policy and plan to expand access to critically needed

person-centered community housing options for individuals receiving developmental services and supports. [Housing Study (2009)]

- Establish state strategic investment priorities with VHDA, DHCD, and DMAS to organize and align federal, state, local, and private housing investment resources with the state housing policy and plan, provide the framework for increasing the development of integrated community housing, maximize public-private partnerships, and develop innovative housing and financing models for individuals receiving developmental services and supports. [Housing Study (2009)]
- Educate the public about the housing needs of individuals receiving developmental services and supports and establish a permanent education and training resource for CSBs and others to continually connect housing and the needs of individuals receiving developmental services and supports. [Housing Study (2009)]

3. CREATE EMPLOYMENT OPPORTUNITIES FOR INDIVIDUALS RECEIVING DEVELOPMENTAL SERVICES AND SUPPORTS THROUGH COORDINATION WITH THE GOVERNOR'S ECONOMIC DEVELOPMENT AND JOB CREATION COMMISSION.

Implementation Focus Areas

- Coordinate with the Governor's Economic Development and Job Creation Commission established under Executive Order 1 (2010) to create economic and workforce development and job creation opportunities for individuals receiving developmental services and supports.
- Use the State Employment Leadership Network as a resource for developing employment supports models and options and create opportunities for people who are providing employment supports to come together to share information about creating employment opportunities for individuals receiving developmental services and supports.
- Expand employment supports models that are specifically designed to keep individuals employed over the long-term using follow-along and employer support.
- Expand school to work transition programs that expose students to job opportunities and enable them to graduate with jobs in place.
- Partner with the DRS to provide employment supports that are tailored to the needs of individuals with intellectual disability.
- Create a model to provide support for individuals interested in developing their own businesses.

4. PROVIDE LEADERSHIP AND PARTICIPATE IN INTERAGENCY PLANNING CURRENTLY UNDERWAY TO IDENTIFY RESPONSIBILITY AT THE STATE LEVEL FOR COORDINATING AND PROVIDING SERVICES TO INDIVIDUALS WITH DEVELOPMENTAL DISABILITIES INCLUDING AUTISM SPECTRUM DISORDERS.

Implementation Focus Areas

- Implement the recommendations of the interagency plan to promote state-level accountability and coordination of services for individuals with developmental disabilities, including autism spectrum disorders.

5. STRENGTHEN THE CAPABILITY OF THE CASE MANAGEMENT AND SUPPORT COORDINATION SYSTEM TO SUPPORT INDIVIDUALS RECEIVING DEVELOPMENTAL SERVICES AND SUPPORTS.

Implementation Focus Areas

- Implement the recommendations of the case management and support coordination capacity workgroup.

V. Department of Behavioral Health and Developmental Services Major Activities

In addition to implementing the behavioral health and developmental services initiatives, the DBHDS will be engaged in the following major activities:

1. Participate in the work of the Secretary of Health and Human Resources' Office of Health Care Reform and develop strategies to strengthen collaboration between the preventive and primary health care and the behavioral health and developmental services systems;
2. Address sexually violent predator (SVP) service capacity issues, including obtaining necessary resources to safely operate the Virginia Center for Behavioral Rehabilitation and provide appropriate SVP rehabilitation and treatment services; and
3. Develop information technology initiatives to implement electronic health records (EHR) and health information exchange (HIE) with state facilities, CSBs, other pertinent healthcare and provider agencies, facilitate quality management, and perform quality management and outcomes oversight.

VI. Conclusion

The Creating Opportunities Plan affirms the DBHDS vision and builds on the foundation established in previous planning efforts, including the Integrated Strategic Plan. To enhance the ability of the behavioral health and developmental services system to perform its core function of providing individualized services and supports that are tailored to meet the particular needs of individuals, the plan identifies a number of strategic initiatives and major activities that will guide the work of the DBHDS over the next three and a half years. Successful implementation of these initiatives and major activities will continue progress toward achieving a community-focused system of behavioral health and developmental services and supports that increases opportunities for and enriches the lives of individuals receiving services.

Appendix A

Behavioral Health Services Planning Team and Developmental Services Planning Team Membership

Behavioral Health Services Planning Team

Paul Gilding, Convener, DBHDS
Jack Barber, Western State Hospital
Mark Blackwell, Substance Abuse and Addiction Recovery Alliance
Kathy Drumwright, Virginia Beach CSB
Steve Herrick, Piedmont Geriatric Hospital
Karen Lawson, DMAS
Betty Long, Virginia Hospital and Health Care Association
Dan Longo, Colonial CSB
Janet Lung, DBHDS
Jim Martinez, DBHDS
Lisa Moore, Mount Rogers CSB
John Morgan, Voices for Virginia's Children
Mike O'Connor, Henrico Area Mental Health and Developmental Services
Mellie Randall, DBHDS
Michael Shank, DBHDS
Mira Signer, NAMI Virginia
Becky Sterling, Mental Health Planning Council Chair, Peer Provider/Advocate
Gina Wilburn, Blue Ridge Behavioral Healthcare

Developmental Services Planning Team

Heidi Dix, Convener, DBHDS
Paul Babcock, Arc of the Peninsula
Teri Barker-Morgan, Virginia Board for People with Disabilities
Pat Bennett, PAIR
Ron Branscome, Rappahannock Area CSB
Debbie Burcham, Chesterfield CSB
Howard Cullum, Arc of Virginia
Mary Ann Discenza, DBHS
Jennifer Fidura, Virginia Network of Private Providers
Terry Smith, DMAS
Janet Lung, DBHDS
Lynnie McCrobie, VACSB ID Council (Middle Peninsula-Northern Neck CSB)
Cindy Gwinn, DBHDS
Lisa Poe, Virginia Network of Private Providers
Lee Price, DBHDS
Betty Thompson, Parent
Natalie Ward, VACSB ID Council (Hampton-Newport News CSB)
Dale Woods, Southwestern Virginia Training Center
Alan Wooten, VACSB ID Council (Fairfax-Falls Church CSB)
Dawn Machonis, Partnership for People with Disabilities

Appendix B

Individualized Behavioral Health and Developmental Services and Supports

The following lists of identified populations and behavioral health and developmental services and supports were developed in consultation with the Behavioral Health Services and Developmental Services Planning Teams. Definitions of the identified populations are not eligibility criteria for receipt of services.

Behavioral Health

Individualized wrap-around packages of services and supports to meet the particular needs of individuals in the following groups served by the behavioral health services system may include the following services and supports.

- Persons of all ages with mental health or substance abuse problems or co-occurring mental health and substance use disorders who are:
  - ♦ in severe distress or crisis,
  - ♦ at risk of causing or suffering serious harm, or
  - ♦ at risk of arrest and

  who need urgent or emergency services:
  - o Telephone counseling and referral
  - o Emergency assessment, evaluation, or preadmission screening
  - o Mobile (outreach) crisis intervention, including in-home crisis care
  - o Psychiatric consultation and medication
  - o Peer support services
  - o Residential crisis stabilization
  - o Detoxification services in a variety of settings
  - o Acute, short-term (i.e., up to two weeks) inpatient psychiatric or substance abuse hospitalization
- Adults, including older adults, with serious mental illness or adults, including older adults, with co-occurring mental health and substance use disorders who need long-term treatment, rehabilitative services, and related supports to promote recovery:
  - o Assessment and evaluation
  - o Case management
  - o Outpatient counseling
  - o Intensive outpatient services
  - o Medication and medication education
  - o Assertive community treatment (PACT and ICT)
  - o Psychiatric rehabilitation and day treatment
  - o Peer support services
  - o Wellness management
  - o Homeless outreach and transition to services
  - o Detoxification services in a variety of settings
  - o Residential services with a wide range of supports
  - o Housing support
  - o Employment supports
  - o Benefits acquisition
  - o Intermediate inpatient psychiatric hospitalization for individuals who no longer need acute inpatient hospitalization but still require highly structured and intensive psychiatric inpatient services to address complex needs, including behavioral challenges

- Adults, including older adults, with substance use disorders, including substance abuse and dependence, who need long-term treatment and related supports to promote recovery
    - Assessment and evaluation
    - Case management
    - Detoxification services in a variety of settings
    - Outpatient counseling (individual and group)
    - Wellness management
    - Intensive outpatient services
    - Medication-assisted treatment
    - Day treatment
    - Residential services with a wide range of supports
    - Housing supports
    - Employment supports
    - Peer support services
- Children and adolescents who have mental health or substance use problems or co-occurring mental health and substance use disorders and who are at risk of involvement or are being served in the juvenile justice system or other out-of-home placement, who are at risk of being or have been expelled from school, or who require long term community mental health or substance abuse treatment and other supports.
    - Assessment and evaluation, including CSA
    - Case management
    - Intensive Care Coordination (limited caseload, intensive case management funded by CSA)
    - Outpatient services
        - Individual, family, and group therapy (office-based)
        - Psychiatric evaluation, including tele-psychiatry
        - Medication management and support
        - Intensive outpatient services
        - Intensive in-home services
        - Educational support for families and skills training
    - Day treatment (school-based)
    - Respite services
    - Supportive residential services for children in therapeutic foster care and group homes

Developmental Services

Individualized wrap-around packages of services and supports to meet the particular needs of individuals in the following groups served by the developmental services system may include the following services and supports:

1. For individuals with intellectual disability:
    A. Whose level of intellectual disability is so severe that they require extensive supports:
        - Services and supports needs will likely be met through the Medicaid ID Waiver, but capacity is limited;
        - Case management and support coordination;
        - Services and supports gaps include:
            - Employment support to keep the individual employed over the long term using follow-along and employer support,
            - Therapeutic services (OT, PT, speech-language, audiology, psychology),

- Guardianship,
- Dental services,
- Urgent care center services (rather than emergency rooms), and
- Transportation;

B. Who are medically fragile or have one or more chronic physical health or sensory conditions:
   - Basic services and supports needs will likely be met through the Medicaid ID Waiver, but capacity is limited;
   - Medical needs will likely be met through Medicaid;
   - Case management and support coordination;
   - Services and supports gaps include:
     - Dental services,
     - Medical practitioners with specialized training in meeting the health needs of individuals with intellectual disability,
     - Skilled nursing liaison with medical practitioners and oversight,
     - Therapeutic services (OT, PT, speech-language, audiology, psychology),
     - Direct care staff with skills to monitor health conditions,
     - Adaptive equipment and assisted technology,
     - Respite services,
     - Guardianship, and
     - Specialized skilled nursing services in rehabilitation facilities (nursing homes);

C. Who have behavioral challenges, including involvement in the criminal justice system or a co-occurring disorder or disability such as a mental illness or autism spectrum disorder:
   - For those individuals who are eligible, basic services and supports needs will likely be met through the Medicaid ID Waiver, but capacity is limited;
   - Case management and support coordination;
   - Services and supports gaps include:
     - Full crisis care system that includes crisis intervention, psychiatric consultation, acute psychiatric hospitalization (not an option for individuals with intellectual disability), crisis stabilization, and behavioral supports and in-home interventions,
     - Guardianship,
     - Dental services, and
     - Transportation;

D. Who have specialized supports needs related to their age, i.e., older adults:
   - For those individuals who are eligible, basic services and supports needs will likely be met through the Medicaid ID Waiver, but capacity is limited;
   - Case management and support coordination;
   - Services and supports gaps include:
     - Appropriate day services and supports for individuals who do not have stamina – need flexibility for these individuals to age in place,
     - Skilled nursing services,
     - Therapeutic services (OT, PT, speech-language, audiology, psychology),
     - Guardianship,
     - Dental services, and
     - Transportation; or

E. Who need intermittent or limited supports or assistance:
   - Employment supports,
   - Affordable housing and housing supports,

- Afterschool and summer programs for children and adolescents, and
- Transition services from school to adult services and teacher training.

2. For infants and toddlers, from birth to three years of age, who have been diagnosed with developmental delay, atypical development, or a physical or mental condition that has a high probability of resulting in developmental delay:
    - Child care,
    - Service coordination,
    - Respite services,
    - Therapeutic services (OT, PT, speech-language, audiology, psychology),
    - Educational services,
    - Assistive technology,
    - Transportation, and
    - Transition to schools and community resources.

Appendix C

Background Paper: Where the Behavioral Health Services System Is Headed

The following background paper was developed by the DBHDS to inform the work of the Behavioral Health Services Planning Team.

Accomplishments and Progress on Plan Initiatives and Recommendations

Successful implementation of recovery-oriented, person-centered, and integrated system of services and supports

- Developed a Vision Statement for the system - *a consumer-driven system of services and supports that promotes self-determination, empowerment, recovery, resilience, health, and the highest possible level of consumer participation in all aspects of community life.*
- Adopted State Board Policy 1040 affirming consumer and family member involvement in the development, operation, and evaluation of Virginia's public behavioral health and developmental services system.
- Supported public education about mental illness and recovery through production of the *Voices of Hope and Recovery* film and sponsorship of National Alliance on Mental Illness (NAMI) *In Our Own Voice* project.
- The DBHDS established a policy to eliminate use of prone restraint.
- Implemented a seclusion and restraint reduction program in all state hospitals and established assertive training programs at CSH and CCCA to support staff in decreasing the use of seclusion and restraint.
- Instituted annual self assessments of recovery orientation in CSBs (ROSI) and state facilities. Results are incorporated into CSB quality improvement and state hospital Recovery Plans.
- In FY 2009, 43 Wellness Recovery Action Planning (WRAP) facilitators trained by the VOCAL REACH program led 159 WRAP groups that resulted in 926 people with mental illness completing their own individual WRAP plans. To date, 130 WRAP facilitators have been certified through the REACH program.
- Increased financial support to statewide consumer support networks, peer-run service providers, and family support organizations, including VOCAL, Substance Abuse and Addiction Recovery Alliance of Virginia (SAARA), NAMI-VA, Mental Health America-Virginia, and Federation of Families for grassroots recovery-oriented supports for individuals receiving services and families for direct peer support services, consumer and family education, leadership development, and public education and awareness.
- Amended Virginia's *Health Care Decisions Act* to allow psychiatric advance directives, enabling individuals receiving services to have a voice in treatment provided to them when they are incapacitated.
- Supported the organization of the Virginia Peer Specialist Coalition, which includes approximately 120 direct service peer providers who are working in the publicly funded behavioral health services system. They include PACT team members, peer counselors, drop-in center support staff, and state hospital recovery coaches.
- In FY 2009, employed 84 peers in CSBs and 89 peers in state hospitals to provide direct services to peers (preliminary counts) and established *Peers Employed by the CSB* as a DBHDS Web Accountability measure.

Core array of available and accessible services across the Commonwealth

- Implemented three Regional Reinvestment Projects that:
  - Closed inpatient units at Central State Hospital, Western State Hospital, and Eastern State Hospital, and
  - Transferred state hospital resources to expand community-based local inpatient purchase of services (LIPOS) and crisis stabilization services for individuals who would otherwise require state hospital resources.
- Implemented System Transformation and MH Law Reform and related budget initiatives for systemwide capacity-building throughout the crisis service and community support continuum for adults and youth, including:

  Adults with long-term serious mental illness
  - Added Programs of Assertive Community Treatment (PACT), now totaling 19 statewide, including monitoring of key outcome indicators for housing, employment, criminal justice involvement, local hospitalization;
  - Expanded LIPOS, emergency services, and case management and related services;
  - Enhanced the emergency services continuum to enable CSBs to strengthen preadmission screening, attend all commitment hearings, and manage all mandatory outpatient treatment (MOT) orders and services;
  - Enhanced jail diversion direct services in 10 high impact localities;
  - Established one adult mental health court; and
  - Implemented specialized services and supports for older adults, in HPR II and HPR V

  Individuals in Crisis
  - Established14 residential crisis stabilization units.

  Adults with Substance Dependence
  - Established seven Recovery Support Programs for people with substance use and co-occurring disorders;
  - Added Oxford houses, self-governing residences for people in various stages of recovery supported through contract with Oxford House, Inc. Currently 90 in operation;
  - Enhanced jail diversion direct services in 10 high-impact localities, with most CSBs offering basic services;
  - Supported six adult and eight youth drug courts; and
  - Funded medication-assisted treatment (methadone, Suboxone) for persons dependent on opiate-based prescription pain medication in 14 CSBs.

  Children and Adolescents
  - Established on-site CSB mental health and substance abuse services at each juvenile detention facility statewide; and
  - Implemented intensive care coordination in all CSBs and enhanced day treatment services in schools, case management, and intensive in-home services

Funding incentives and practices that support and sustain quality care, promote innovation, and assure efficiency and cost effectiveness

- New CSA state and local match ratios create financial incentives that favor community care.
- Annual financial incentives awarded to 18 Projects for Assistance in Transition from Homelessness (PATH) sites are based on key performance measures.
- "Housing First" project in Richmond area for homeless individuals with mental health and substance use disorders used $450,000 in federal mental health block grant funds as seed

- Implemented pharmacy utilization management tools at CSBs, including uniform eligibility requirements, prescription monitoring, cost reporting, and feedback to prescribers on prescribing practices.
- Expanded Medicaid coverage to allow eligible persons with substance use disorders to receive Medicaid-reimbursable services.

Appropriate and efficient state facility and community infrastructure and technology

- Initiated the $3.2 million GE Centricity Project for a new pharmacy replacement system. This project will serve as building block for an electronic health record (EHR).
- Implemented an automated CSB data reporting system (CCS 3) to eliminate manual reporting of CSB data about services and individuals receiving services.
- New facilities under construction at ESH and WSH will provide safer and more appropriate treatment environments in more efficient physical plants.

Competent and well-trained workforce

- CSBs adopted evidence-based practices, which include PACT, Multisystemic Therapy, Therapeutic Foster Care, Functional Family Therapy, Integrated Treatment for Co-Occurring Disorders.
- In partnership with the OAG and ILPPP, provided 12 annual training sessions for juvenile and adult forensic evaluators to qualify to provide competency to stand trial, mental status at the time of the offense, and other evaluations required by the court.
- Established certification requirements and e-learning curriculum for CSB emergency evaluators and court-appointed independent examiners, including academic qualifications, completion of a 25-module curriculum, and supervisory approval. Currently used by 2000+ enrollees through the DBHDS "External Users" portal.
- Provided 40-hour CIT training to over 1,000 officers in 22 localities to improve law enforcement and mental health system response to mental health emergencies, reduce incarceration, and increase safety for officers, individuals, and communities.
- Trained 80 mental health peer specialists to qualify as Medicaid paraprofessional providers.
- Partnered with Region Ten CSB, Piedmont Community College, and DRS to support the Virginia Human Services Training academy (VHST) for up to 15 consumers each year to learn to work as peer providers in CSBs and other human service settings.
- Conducted a Virginia Service Integration Program (VASIP) Workforce Survey in all state hospitals to assess co-occurring treatment capability.

Effective service delivery (partnerships and consistent practices) and utilization management

- Enhanced utilization management of intensive services:
  - Intensive care coordination for children's services,
  - Regional acute inpatient services and crisis stabilization for adults, and
  - Discharge planning that links all CSBs and state facility treatment teams in a secure web-based platform.
- Established state, regional, and local partnerships in policy and service delivery:
  - Increased access to behavioral health and brain injury services and other supports for veterans through the Virginia Wounded Warriors Program;

- Implemented statutory and policy reforms as a partner in the Commission on Mental Health Law Reform; and
- Strengthened suicide prevention planning and coordination of resources and training in partnership with the Virginia Department of Health (VDH), VDH Office of the Chief Medical Examiner, Department for the Aging, Department of Veterans Services, CSBs, and the statewide Suicide Prevention Coalition.

Services meet highest standards of quality and accountability

- Implemented performance measures regarding timely telephone and face-to-face response by CSBs in emergencies.
- Amended the Performance Contract to require CSBs to conduct COMPASS self-assessments of capability to provide integrated treatment for individuals with co-occurring disorders.
- Implemented web-based performance and accountability measures on the DBHDS web site.

Challenges and Opportunities

Challenges:

- There continues to be a need for strong central office, state facility, and CSB leadership to enhance person-centered and recovery-oriented practice, integrated services, trauma-informed care, and reduction of seclusion and restraint and involuntary treatment.
- Virginia needs to define a "core array" of community-focused services and supports and establish adequate capacity that assures equitable access at the state and local levels.
- There is no statewide workforce development and training strategy or funding that assures dissemination of best practice and supports provider organizations to adopt and sustain best practices, workforce training, and provider certification.
- The current State Medicaid Plan does not reflect contemporary recovery-oriented best practices, including wellness management, WRAP, peer support, and integrated co-occurring treatment.
- The implementation target date (2014) for electronic health records implementation is shorter than the required three to five year development timeframe and the DBHDS workforce is largely unprepared to adopt and utilize electronic health records technology.
- The behavioral health services system is highly complex, with partner agencies that may have competing priorities for limited resources.
- Across the services system, accountability means different things to different people.

Opportunities:

- Services system stakeholders support Virginia's vision for the system and are looking for leadership that supports and advances the vision.
- The Governor's focus on economic opportunity and jobs could be leveraged to expand employment supports and related community integration initiatives.
- The current environment creates opportunity to integrate funding and services in ways that can enhance service effectiveness and create innovation and efficiency to increase desired outcomes with existing resources.
- The current environment creates opportunity to advance evidence-based and best practices, improve statewide access to a "core array of behavioral health services," and enhance provider competencies.

- There is well-developed knowledge about how to manage and support adoption of evidence-based and best practices and current system change initiatives such as VASIP provide a model for adopting best practices more widely.
- Initial steps such as the DBHDS web-based performance and accountability measures and improved DBHDS and CSB data infrastructure provide a foundation to further enhance services system accountability and transparency.

What's Left to Be Done

- Increase the capacity of the community behavioral health services system to respond to the needs of individuals with a full range of challenges and to engage and support individuals in their recovery.
- Implement a minimum core array of CSB adult and children's services to assure statewide access to those services and enable individuals receiving services to have more choice based on their own preferences, not based on where they live.
- Increase opportunities to engage individuals and family members at all levels and in all aspects of service development, implementation, and oversight and to expand the peer workforce.
- Increase the capacity of the services system to treat individuals in welcoming environments and with person-centered practices that promote the highest possible level of individual choice and participation in all aspects of community life, including work, school, family, and other meaningful relationships.
- Develop and implement a statewide, comprehensive (community and state facility) workforce improvement program that reflects state-of-the-art learning mechanisms, such as:
  - Learning centers where CSB, state facility, and private provider staff can learn best practices in delivery of services and supports and effective leadership development and program management practices. Learning centers could provide curriculum development, teaching, consulting and mentoring services, and certification for certain providers, including case managers and emergency services providers; and
  - Training of managers and clinical supervisors as change agents to implement best practices.
- Achieve the most effective and efficient use of Medicaid and state resources, including leveraging state funding and other revenues, where possible, at the state and CSB levels, to build system capacity and integrating state funding for state facilities and CSBs into a single behavioral health resource pool to enhance flexibility and encourage innovation and efficiency.
- Expand the responsiveness of the services system to provide trauma-informed care to individuals who are in crisis.
- Strengthen DBHDS oversight of behavioral health services and supports to enhance their quality, effectiveness, and efficiency.
- Implement electronic health records.
- Improve relationships with private hospitals, hospital emergency rooms, courts, and law enforcement to provide more effective treatment and utilization management procedures.
- Expand and strengthen the quality, effectiveness, and consistency of case management and care coordination services.

Appendix D

Background Paper: Where the Developmental Services System Is Headed

The following background paper was developed by the DBHDS to inform the work of the Developmental Services Planning Team.

Accomplishments and Progress on Plan Initiatives and Recommendations

Successful implementation of person-centered system of services and supports

- Incorporated person-centered planning (PCP) practices in the Medicaid Intellectual Disability (ID) and Day Support (DS) Waivers and Intermediate Care Facilities for Persons with Mental Retardation (ICFs/MR), including state training centers, through the following:
  - Developed, in collaboration with multiple agencies and stakeholders, a uniform person-centered planning format and process to be used in developing individual support plans for individuals in community and training center environments;
  - Trained more than 3,544 case managers and waiver providers and key staff in all five training centers on the new person-centered individual support plan.
  - Implemented "The Learning Community," an internationally recognized PCT (Person Centered Thinking) training curriculum, with 16 professionals receiving endorsement and 5 current applicants enrolled in the process of becoming endorsed as PCT trainers.
  - Developed PCT Mentoring capacity in Virginia, with three professionals, including one from the DBHDS, in the final stages of receiving endorsement as the first PCT Mentors in Virginia. With completion of this process by April 30, 2010, these professionals will be able to train trainers in "The Learning Community" curriculum.
  - Trained 1,618 providers and case managers in the 2-day PCT training.
- Incorporated person-centered language into the 2009 ID Waiver three-year renewal application for the first time and in the approved emergency regulations related to the ID Waiver renewal. Revisions to the final Waiver regulations and accompanying MR/ID Community Services Manual are now in progress.
- Initiated the State Employment Leadership Network (SELN) project, promoting "employment first" awareness and policy changes with an emphasis on person-centered planning.
- Launched a three-year rollout of the *Supports Intensity Scale*™ (SIS™), one of the first person-centered individual needs assessments for persons with developmental disabilities, across the Medicaid-funded services system in community services and training centers. Trained 1,943 SIS administrators and interviewers.

Core array of available and accessible services across the Commonwealth

- Trained 129 individuals in the Positive Behavioral Supports curriculum and endorsed 44 of those trained as qualified to bill for Medicaid reimbursable services as behavior consultants through a collaborative effort with the Partnership for People With Disabilities.
- Promoted use of the sponsored residential model of service, previously used almost exclusively in southwestern Virginia by approximately 10 providers, resulting in expansion to 27 providers operating statewide.
- Initiated the Day Support Waiver in FY 2006 with 300 slots to offer Day Support, Prevocational, and Supported Employment services to individuals on the Waiver urgent and non-urgent waiting lists according to date of need.

Funding incentives and practices that support and sustain quality care, promote innovation, and assure efficiency and cost effectiveness

- Added 2,450 ID Waiver slots since FY 2004 with start-up funds accompanying each slot to help increase the capacity of the community to provide adequate supports. The number of total available slots is now 8,162.
- Increased the supported employment reimbursement rate in the Medicaid ID and DD Waivers to make them competitive with the DRS individual supported employment rate.
- Increased the ID Waiver rate for the first time in 15 years with a 10% increase in the congregate residential rate and a 5% increase in all other services followed by a 15% northern Virginia differential for all waiver services the following year.
- Used the Medicaid *Money Follows the Person* demonstration to move eight individuals from nursing homes and 60 individuals from training centers and community ICFs/MR into more homelike community settings.
- Demonstrated the conversion of Medicaid dollars supporting individuals in training centers to ID Waiver slot funding to enable transition of 30 individuals from SEVTC to community settings.
- Expanded Medicaid support for early intervention services by adding coverage for additional services and increasing the reimbursement rate for previously-covered services.

Appropriate and efficient state facility and community infrastructure and technology

- Appropriated capital funds for the first time in many years to construct community homes for individuals leaving SEVTC and CVTC
- Initiated replacement of SEVTC with a new facility of no more than 75 beds.
- Designed an electronic system for enrollment and pre-authorization of Medicaid ID and DS Waiver services, management of the statewide waiting list, and management of information required for reporting to the Centers for Medicaid and Medicare (CMS) regarding the 17 Quality Assurances scheduled to be phased in beginning in September, 2010.

Competent and well-trained workforce

- Enrolled over 4,000 community staff employed in 49 different agencies in the College of Direct Supports during the three year period that DBHDS has sponsored it.
- Trained 208 case managers since December 2008 through a web-based case management training program.
- Implemented a certification process for early intervention practitioners. As of March 15th, there were 1,036 individuals certified as early intervention practitioners affiliated with 91 public and private provider agencies.

Effective service delivery (partnerships and consistent practices) and utilization management

- Provided support to 271 individuals with intellectual disability under the Public Guardianship Program through a partnership agreement between the DBHDS and Virginia Department for the Aging.
- Developed the Systems Transformation Grant, funded by CMS, through a partnership with the DMAS, DBHDS, Department of Social Services, and other agencies that has led to the establishment of cross-systems person-centered training, design of new electronic systems for managing information, and improved methods of delivering necessary information to families in need of service.
- Progress continues in the five regions of the state toward more efficient and appropriate use of state operated and community resources as critical needs emerge through the development of Regional Utilization Management Agreements.
- Established collaborative relationships with various departments, offices, agencies, and stakeholders have produced *House Document 76*, a blueprint for the design of the future role of

training centers as support to individuals living in the community, the MR System Study, and the Housing Study for persons with developmental disabilities.

- Decreased the average daily census of the training centers over the past five years from 1,524 to 1,276 by diverting long term admissions and discharging many persons ready for discharge.

Services meet highest standards of quality and accountability

- Regularly scheduled quarterly meetings are held between the DBHDS Office of Developmental Services and Long-term Services staff at DMAS to review quality measures and outcomes for reporting to CMS on compliance with the 17 Quality Assurances.
- Established a team of DBHDS central office, CSB, and Virginia Office of Protection and Advocacy staff to ensure admission and discharge practices are consistent among all state training centers.

Challenges and Opportunities

Challenges:

- Quality varies greatly among providers of Medicaid Waiver services and many providers are not aware of best practices.
- The current ID Waiver does not provide the level of supports and reimbursement rates for targeted services that would make it a truly effective alternative for individuals with needs for high intensity services.
- Waiver reimbursement rates do not consistently promote services with the highest social value (e.g., employment), the most person-centered outcomes (e.g., smaller residential options and community-based day support), or the most effective means of supporting individuals with extensive medical or behavioral needs.
- There is a continuing need to develop administrative capacity to provide oversight, training, and technical support to ensure compliance with regulations and quality care standards to support individuals with developmental disabilities in a rapidly growing community services system.
- State and partner agency training resources are limited generally, including DBHDS central office training and technical support capacity for new providers and to improve staff competencies across the spectrum of support service delivery.
- Sustainability of early intervention services is jeopardized by limited federal, state, and local funding, especially when federal (ARRA) stimulus funds are no longer available.
- A variety of agencies serve as local lead agencies for Part C, which increases the complexity of the program.
- Individuals in training centers could be served in the community if adequate supports, including targeted medical and behavioral interventions, were available to them

Opportunities:

- A general recognition among stakeholders, providers, and individuals and their families that changes are needed in the services system to better support those with needs presents an opportunity for greater collaboration to build efficiencies and expand services and supports capacity
- There are increased opportunities to work collaboratively with DMAS on improving Consumer-Directed Services Facilitation services.
- Existing partnerships at the local, regional, and state levels support strategic planning and system improvement.

- Improvements have been made in gathering and sharing available data regarding training center and community utilization for easy and quick reference by all who need it.
- The DBHDS more effectively supports case managers and support coordinators.
- Collaborative efforts are underway to define responsibilities and strengthen relationships among the various agencies that support individuals with developmental disabilities.
- The potential exists to efficiently combine the Medicaid DD and ID Waivers, while working out the differences related to case management and support coordination provision and slot assignment from differently managed waiting lists.

What's Left to Be Done

- Increase the capacity of the developmental services system for individuals with a full range of challenges in order to meet the needs of individuals who are currently residing in the community and those in training centers who are waiting for discharge.
- Implement applicable recommendations of the interagency planning currently underway to identify responsibility at the state level for coordinating and providing services go individuals with developmental disabilities.
- Strengthen the capacity of the services system to provide medical, dental, and behavioral supports in the community as close to individuals' homes as possible.
- Increase the capacity of the services system to treat individuals in welcoming environments and with person-centered practices that promote the highest possible level of individual choice and participation in all aspects of community life, including work, school, family, and other meaningful relationships.
- Achieve the most effective and efficient use of Medicaid resources.
- Expand the responsiveness of the services system to provide trauma-informed care to individuals who are in crisis that allows them to remain in or quickly return to their home communities.
- Expand and strengthen the quality and effectiveness of case management and services coordination.
- Strengthen DBHDS oversight of developmental services and supports to enhance their quality, effectiveness, and efficiency.

Appendix E

Department of Behavioral Health and Developmental Services Statutory Authority

State Statutes

• Article 16 (§ 2.2-2648 et seq.) of Chapter 26 of Title 2.2 of the Code of Virginia establishes the State Executive Council for Comprehensive Services and requires the Commissioner of the Department of Behavioral Health and Developmental Services to be a member of it.

• Article 22 (§ 2.2-2664 et seq.) of Chapter 26 of Title 2.2 of the Code of Virginia establishes the Virginia Interagency Coordinating Council, as required by Part C of the Individuals with Disabilities Education Act (20 U.S.C. § 1431 et seq.), and requires the Commissioner of the Department of Behavioral Health and Developmental Services to appoint a representative to serve on it.

• Article 31 (§ 2.2-2696 et seq.) of Chapter 26 of Title 2.2 of the Code of Virginia establishes the Substance Abuse Services Council to advise the Governor, the General Assembly, and the State Board of Behavioral Health and Developmental Services on broad policies and coordinate the Commonwealth's public and private efforts to control substance abuse. This article requires the Office of Substance Abuse Services in the Department to provide staff assistance to the Council and prepare an annual report and an annual Comprehensive Interagency State Plan that includes program outcomes by agency (subsection G of § 2.2-2696 and § 2.2-2697).

• Chapter 53 (§ 2.2-5300 et seq.) of Title 2.2 of the Code of Virginia establishes the Early Intervention Services System to implement Part C of the Individuals with Disabilities Education Act (20 U.S.C.1401 et seq.) and describes the lead agency's responsibilities. The Department is the lead agency (§ 2.2-5304).

• Article 13 (§ 9.1-187.A.) of Chapter 1 of Title 9.1 of the Code of Virginia requires the Department of Criminal Justice Services and DBHDS to support the development and establishment of crisis intervention team programs in areas throughout the Commonwealth.

• Article 16 (§16.1-335 et seq.) of Chapter 11 (§ 16.1-241 et seq.) of Title 16.1 of the Code of Virginia sets out the Psychiatric Inpatient Treatment of Minors Act, authorizing the Department to conduct evaluations of the competency of juvenile defendants to stand trial. These sections also require the Commissioner to approve the training for and qualifications of individuals authorized to conduct juvenile competency evaluations and provide all juvenile courts with a list of guidelines to use in qualifying individuals as experts in matters relating to juvenile competency and restoration. The courts also may refer juveniles to a state hospital for an inpatient evaluation of competency under certain circumstances. The DBHDS has responsibility for the provision of restoration to competency to stand trial services to juveniles after a finding of incompetency, evaluation of post-restoration competency, and the commitment of unrestorably incompetent juveniles, if they need inpatient treatment and meet commitment standards, or their certification to training centers.

• Article 8 (§16.1-275) of Chapter 11 (§ 16.1-241 et seq.) of Title 16.1 of the Code of Virginia requires the DBHDS to provide inpatient 10-day mental and physical examinations and treatment at state hospitals. § 16.1-280 contains language enabling the courts to commit juveniles in need of services, or delinquents to state hospitals, including adult state hospital programs for juveniles who have been transferred to circuit court.

• Chapters 11 (§19.2-167 et seq.) and 11.1 (§19.2-182.2 et seq.) of Title 19.2 of the Code of Virginia authorize the Department to provide forensic services to individuals in the criminal justice system, including evaluations of competency, determinations of sanity, restoration to competency services, and treatment services for individuals adjudicated not guilty by reason of insanity. These Code sections also provide that the DBHDS Commissioner approve specialized training for expert

evaluations related to all mental health, sex offending (§19.2-300 & 301), death sentence mitigation (§19.2-264.3:1.1), and determination of mental retardation in capital cases (§19.2-264.3:1.1) matters in which a mental health evaluation is provided as part of the proceedings. The Commissioner can be required by the courts to admit any defendant in these categories to a state hospital for these evaluations. Also, §19.2-264.3:1.1B(1) requires that the Commissioner maintain an exclusive list of standardized measures of intellectual functioning generally accepted by the field of psychological testing, to be used for assessing mental retardation in capital cases.

• Section 53.1-40.9 of the Code of Virginia defines a procedure for civil commitment of parolees leaving prisons.

• Chapter 2 (§§ 37.2-200 to 37.2-204) of Title 37.2 of the Code of Virginia establishes the State Board of Behavioral Health and Developmental Services and outlines its duties and powers, which include developing programmatic and fiscal policies governing the operation of state hospitals, training centers, community services boards, and behavioral health authorities.

• Chapter 3 (§§ 37.2-300 to 37.2-319) of Title 37.2 of the Code of Virginia establishes the Department of Behavioral Health and Developmental Services under the supervision and management of the Commissioner. This chapter outlines duties and powers of the Commissioner, including supervising and managing the Department and its state facilities, which provide care and treatment of individuals with mental health disorders and treatment, training, or habilitation of individuals with intellectual disability (mental retardation). State facilities also provide inpatient pharmacy services, geriatric services for older adults, inpatient medical services, inpatient forensic services, education and training programs for school-age individuals, and facility administrative and support services. This chapter also lists other responsibilities of the Department, including the development of a six-year comprehensive plan, the administration, planning, and regulation of substance abuse services in the Commonwealth, and the administration of the Behavioral Health and Developmental Services Trust Fund.

• Chapter 4 (§§ 37.2-400 to 37.2-440) of Title 37.2 of the Code of Virginia describes the protections available to individuals receiving behavioral health and developmental services, including their human rights and the Department's licensing of providers, and establishes the Office of the Inspector General for Behavioral Health and Developmental Services.

• Chapter 5 (§§ 37.2-500 to 37.2-512) of Title 37.2 of the Code of Virginia authorizes the establishment by local governments and operation of community services boards (CSBs) to provide community behavioral health and developmental services and requires the Department to develop and initiate negotiation of performance contracts with CSBs and to fund CSBs. This chapter requires the Department to establish minimum qualifications and salary ranges for CSB executive directors and to approve the selection of operating CSB executive directors for adherence to those qualifications and the salary range. This chapter requires CSBs to provide emergency services and, subject to the availability of funds appropriated for them, case management services and to provide preadmission screening and discharge planning services.

• Chapter 6 (§§ 37.2-600 to 37.2-615) of Title 37.2 of the Code of Virginia authorizes the establishment by a specified county or city and operation of a behavioral health authority (BHA) to provide community behavioral health and developmental services and requires the Department to develop and initiate negotiation of performance contracts with the BHA and to fund the BHA. This chapter requires the Department to establish minimum qualifications and salary ranges for a BHA chief executive officer and to approve the selection of a BHA chief executive officer for adherence to those qualifications and the salary range. This chapter requires a BHA to provide emergency services and, subject to the availability of funds appropriated for them, case management services and to provide preadmission screening and discharge planning services.

• Chapter 7 (§§ 37.2-700 to 37.2-721) of Title 37.2 of the Code of Virginia authorizes the Department to perform certain functions related to the operation of state hospitals and training centers (state facilities) that serve individuals with mental health disorders or intellectual disability respectively.

• Chapter 8 (§§ 37.2-800 to 37.2-847) of Title 37.2 of the Code of Virginia addresses admissions to and discharges from state hospitals and training centers, voluntary admission, involuntary commitment, and admissions to private facilities. This chapter requires certification of CSB preadmission screening evaluators and independent examiners by the Department.

• Chapter 9 (§§ 37.2-900 to 37.2-920) of Title 37.2 of the Code of Virginia authorizes the civil commitment of sexually violent predators, requires the Department to operate or contract for a secure confinement facility to provide behavioral rehabilitation services to them, and requires the Department to implement conditional release orders. This chapter also establishes the Office of Sexually Violent Predator Services in the Department to administer the duties of the Department under this chapter.

Federal Statutes and Regulations

• Public Law 102-321 authorizes the federal Substance Abuse and Mental Health Services Administration to provide federal funds to the Department for community mental health services. This law requires the establishment of a Mental Health Planning Council and an annual application and implementation reports and establishes data reporting requirements, restrictions on expenditures, and maintenance of effort requirements.

• The Nursing Home Reform provisions of the Omnibus Budget Reconciliation Act of 1987 requires Pre-admission Screening and Resident Review of all prospective nursing facility admissions and individual residents who experience a change of condition and who may require specialized services for mental illness, intellectual disability, or related conditions.

• Part C of the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.) and 34 CFR 303.303.11-325 under the Individuals with Disabilities Education Act authorize the state to implement a statewide, comprehensive, coordinated, multidisciplinary, interagency system of early intervention services for infants and toddlers with disabilities and their families. The Individuals with Disabilities Education Act also defines who receives special education services in state facilities.

• Sections 1921-1954 of the Public Health Services Act authorize the federal Substance Abuse Treatment and Prevention (SAPT) Block Grant, providing federal funds to the Department for community substance abuse treatment and prevention services.

• The federal Centers for Medicaid and Medicare (CMS) establishes certification requirements for all ICF/MR beds in training centers operated by the Department and acute care beds and skilled nursing beds at the CVTC.