SEMI-ANNUAL REPORT
OCTOBER 1, 2011 TO MARCH 31, 2012

IN-BRIEF

Office of the Inspector General
Behavioral Health and Developmental Services

G. Douglas Bevelacqua, CIG
Inspector General

May 17, 2012

The Office of the Inspector General created this Semi-Annual Report In Brief (SAR) to provide a synopsis of the key issues covered in greater detail in the full-length SAR for the period ending March 31, 2012. The complete SAR is located at: www.oig.virginia.gov.

The challenges identified in this Semi-Annual Report (SAR) reflect both system vulnerabilities, as outlined in recent OIG reports, as well as new and emerging issues identified by DBHDS and the OIG. The following summary of management challenges is discussed in greater detail in the full Report.

THE DOJ *SETTLEMENT AGREEMENT*: During this reporting period, the Commonwealth and the U. S. Department of Justice reached a settlement regarding Virginia's compliance with the *Americans with Disabilities Act* (ADA) and as interpreted by the *Olmstead* decision.

It was agreed that Virginia would provide services for persons with intellectual disabilities in the most integrated setting appropriate to meet an individual's needs, and that the state would pursue the goals of community integration, self-determination, and quality services.

The ten-year *Agreement* requires an expansion of community-based ID waiver slots, strengthening quality and risk management systems, closing four of Virginia's five training centers, and additional appropriations to support these initiatives.

INCREASING SYSTEMIC ACCOUNTABILITY: As stewards of the state's limited resources, agencies are obliged to hold themselves accountable to the public for the caliber of care they provide.

The development of a viable state-wide quality assurance system serves as a pledge to the public that the various components that comprise the behavioral health and developmental services system of care will work towards the goal of achieving excellence in the services rendered to all qualified persons.

The DBHDS lacks an active broad-based and centralized quality assurance system, and it has had difficulty recruiting and retaining an Assistant Commissioner for Quality Management and Development. The creation of a robust quality assurance system is a necessary ingredient if the DBHDS is to comply with the terms of the recent *Settlement Agreement* with DOJ and to implement the strategies agreed to in past OIG Reports.

INCREASING CRISIS INTERVENTION SERVICES: DBHDS's *Creating Opportunities Implementation Plan* observed that "too

many Virginians do not have access to a basic array of emergency and crisis response services" and concluded that "a safety net of basic services is indeed widely available in Virginia, but just barely."

During this semi-annual reporting cycle, the OIG documented that, while basic safety net services may be available to most citizens, safety net services were not accessible for 72 individuals who, despite meeting statutory criteria for temporary detention, could not be detained for their own safety because no private provider, or state operated facility, would admit them.

CREATING AND SUSTAINING INDIVIDUALIZED AND PERSON-CENTERED SERVICES: The DBHDS has been instrumental in facilitating person-centered and recovery-oriented services for persons who receive services in both the facility and community-based systems of care. The Office of Developmental Services (ODS), in cooperation with other agencies, has led the resurgence of person-centered services in Virginia; however, person-centered and recovery-oriented services in the community are not as consistently developed and monitored as the services provided in the state facilities.

The recent increase in service providers, combined with the anticipated expansion over the next decade in response to the DOJ *Settlement Agreement*, suggests important challenges keeping up with the demand to provide and monitor ongoing person-centered and recovery-oriented services.

During this reporting period, the OIG began its review of residential services for persons with intellectual disabilities to understand how the person-centered initiative is actually being realized by the individual residing in the community. We believe having this current baseline measure will be critical to helping support this initiative, and the recent DOJ settlement makes it clear that everyone shares an interest in this culture becoming the norm.

Specific details are not yet available, as we still have a number of visits scheduled, but so far the OIG has visited 85-90 Waiver Group Homes, Sponsored Residential Homes, and Intermediate Care Facilities for Individuals with Intellectual Disability licensed by DBHDS.

In early May, the OIG received a complaint of abuse that has caused us to reconsider our approach to this survey, and we will be conducting additional surveys of sponsored placements and folding in those results to the final report scheduled for release in June, 2012.

THE EFFECTIVE USE OF STATE RESOURCES: A rebalancing of state funds will be required for the DBHDS to satisfy its commitment to protect the assets of the Commonwealth's system of care for persons receiving behavioral healthcare and developmental services, and to deploy the Commonwealth's limited resources in the most effective and efficient manner.

A six-month review of the barriers to discharge from state-operated facilities for persons deemed discharge ready determined that inadequate community-based supported housing was the primary barrier to discharge for scores of individuals who could have been served in the community for roughly one-fifth of the

annual $214,000 cost of serving a person in a state facility.

The barriers to discharge study revealed that on average 165 individuals, or 13% of the state behavioral health facility census, could have resided in the community.

Moreover, serving this discharge ready cohort in the community would not only be less costly, it would have created bed availability for the additional scores of individuals, meeting TDO criteria, who were denied admission to a state hospital during another recent OIG study.

CRITICAL INCIDENTS: This SAR reflects that, during this reporting period, the OIG received 343 critical incident reports and followed-up on 58 of these incidents. The OIG monitored the 38 deaths that occurred in state-operated facilities during this period, and reviewed all 26 autopsies forwarded by the Medical Examiner's Office.

COMPLAINTS: The OIG responded to 11 complaints from citizens, service recipients, and state employees.

Office of the Inspector General

The Office of the Inspector General (OIG) is established in the VA Code § 37.2-423 to inspect, monitor and review the quality of services provided in the facilities operated by the Department of Behavioral Health and Developmental Services (DBHDS) and providers as defined in VA Code § 37.2-403. This definition includes all providers licensed by DBHDS including community services boards (CSB) and behavioral health authorities (BHA), private providers, and mental health treatment units in Department of Correction facilities.

It is the responsibility of the OIG to conduct announced and unannounced inspections of facilities and programs. Based on these inspections, policy and operational recommendations are made in order to prevent problems, abuses and deficiencies and improve the effectiveness of programs and services. Recommendations are directed to the Office of the Governor, the members of the General Assembly and the Joint Commission on Healthcare.

If you would like more information about these issues, or other activities of the Office of the Inspector General for Behavioral Health and Developmental Services during this reporting period, please refer to the full-length SAR at www.oig.virginia.gov, call (804) 692-0276, fax your questions to (804) 786-3400, or write to:

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COMMONWEALTH of VIRGINIA

Office of the Inspector General

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May 31, 2012

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 (SAR) for the period ending March 31, 2012 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.

In addition to the attached Report, we have included the *OIG SAR In-Brief* that presents a synopsis of the key issues covered in the full-length Semi-Annual Report. We created this abbreviated version to provide an accessible rendering of the Report that can be more easily consumed by interested persons.

During the six months covered by this Report, the OIG conducted announced and unannounced inspections at various facilities operated by the DBHDS and performed a range of other activities as summarized in this Semi-Annual Report.

Sincerely,

G. Douglas Bevelacqua
Inspector General

COMMONWEALTH of VIRGINIA

Office of the Governor

Robert F. McDonnell
Governor

May 30, 2012

General Assembly of Virginia
Capitol Square
Richmond, Virginia

Dear Members of the General Assembly,

The challenges facing Virginia's system of services and supports for people with behavioral health and developmental disorders have been well-documented in a series of studies and reports as well as the "Creating Opportunities" strategic plan developed by the Department of Behavioral Health and Developmental Services ("DBHDS"). As a member of the House of Delegates and Attorney General, I have been committed to strengthening our system of care for behavioral health and developmental services. I am pleased to report that we continue to make significant progress in meeting these challenges, and I want to share some highlights with you.

First, as you are now aware on January 26, 2012, the Commonwealth completed negotiations and signed a settlement agreement with the U.S. Department of Justice which will enable more Virginians with intellectual and developmental disabilities to be supported in integrated community settings of their choice. Though we are awaiting final court approval of the settlement agreement, we are moving forward on several fronts to implement the terms of the agreement. I am grateful for your support for the provision of $60 million into the budget for necessary waiver slots and service development. Fifty-two individuals have already moved into community settings as a result of the sixty waiver slots provided in the first year of the agreement. The Department has initiated Systemic, Therapeutic, Assessment, Respite, and Treatment (START) programs in each region of the Commonwealth, which will for the first time, provide specialized crisis response and stabilization services in community settings for individuals with Intellectual and developmental disabilities. In addition, DBHDS leadership continues to meet regularly with stakeholders to ensure that all communications are open and clear. Thank you for your continued strong support of these efforts.

Second, we have taken significant steps to strengthen overall quality management and improvement of our system of delivery of behavioral health and developmental services. DBHDS selected Western State Hospital and nationally-recognized mental health authority, Dr. Jack Barber, as Interim Medical Director, filling an important leadership role in the DBHDS central office. DBHDS hired additional licensing, human rights, and IT specialists to enhance our ability to oversee and monitor both existing and new services and programs, which are necessary to ensure the safety and well being for this vulnerable population while meeting the requirements of the settlement agreement. The first phase of a comprehensive case manager training program has been completed. This program will ensure that all behavioral health and developmental services case managers are well prepared to fulfill their essential service delivery and accountability functions. The Annual Consultative Audit quality improvement process has expanded to include not only our state hospitals but all training centers as well. DBHDS completed final development of the behavioral health performance measures for CSBs, which will go

into effect in FY 2013 and is actively recruiting for an Assistant Commissioner to lead the quality management division.

Third, we continue to focus on fundamental transformation to a person-centered, recovery-oriented, community based system of services and supports. Services for individuals with intellectual and developmental disabilities have been engaged in this transformation continuously during my administration. I am happy to report that this effort has recently been re-energized in the behavioral health area. Through an initiative called "Bringing Recovery Supports to Scale", behavioral health providers, service recipients and policy-makers are working together to identify opportunities and strategies to help more Virginians recover from serious mental illness and addictions.

Finally, we continue to develop new capacity wherever possible. In the upcoming biennium, there will be additional funding for crisis stabilization and psychiatric services for children. We will also be strengthening our therapeutic "hand-off" capacity in several communities to enable law enforcement and behavioral health providers to divert more persons from the criminal justice system when appropriate. I appreciate your strong support of these capacity-building initiatives as they are critical in ensuring a seamless transition from public safety to public health services

The Inspector General for Behavioral Health and Developmental Services outlines a number of these issues in his May 31, 2012 report, which is attached. This report also summarizes the April 25, 2012 IG report on barriers to discharge facing approximately 165 patients at our state hospitals. These complex clinical, housing, legal, and special needs issues are not new. My administration and those of my predecessors have worked with the General Assembly to address these issues over a number of years. Resolving the issues identified by the Inspector General are identified as a high priority in the DBHDS Creating Opportunities strategic plan and I am pleased with the progress the department and Secretary Hazel have already made to address these issues during difficult economic times.

While there are many areas where continued improvement is still needed, I hope you will agree that there are many very positive developments and we are moving with ever-increasing momentum in the right direction. I am certain that by continuing to work together on these complex issues, we will achieve good progress and that all Virginians will be well-served by our efforts. Thank you again.

Sincerely,

Robert F. McDonnell

2012

OIG Semiannual Report

October 1, 2011 to March 31, 2012

Office of the Inspector General

Behavioral Health and Developmental Services

G. Douglas Bevelacqua, CIG
Inspector General
May 17, 2012

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FOREWORD

The *Mission* of the Office of the Inspector General (OIG) 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.

OIG INSPECTIONS, INVESTIGATIONS AND REVIEWS

INSPECTIONS

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 different shifts. During this semi-annual reporting period, the office conducted unannounced visits at the following state facilities and licensed programs:

- Virginia Center for Behavioral Rehabilitation in Burkeville
- Eastern State Hospital in Williamsburg
- Piedmont Geriatric Hospital in Burkeville

REVIEWS

- The OIG conducted reviews of three deaths that occurred during this period in state facilities.
- There also were 60 unannounced site visits in community residential settings for persons with intellectual disabilities.

INVESTIGATIONS

- The OIG conducted two unannounced investigations following complaints regarding quality of care at CCCA and NVMHI.

REPORTS

During the reporting period, the OIG published the following reports:

- *Review of Behavioral Health Forensic Services,* OIG Report No. 200-11;
- *Review of Emergency Services: Individuals meeting statutory criteria for temporary detention not admitted to a psychiatric facility for further evaluation and treatment. OIG Report No. 206-11;*
- *Review of the Emergency Services* and the *OIG Inspection of the Commonwealth Center for Children and Adolescents*. OIG Report No. 199-11;
- Also, during this reporting period, the OIG conducted a *Review of the Barriers to Discharge in State-Operated Adult Behavioral Health Facilities*. The *Barrier's Report* is awaiting the DBHDS's responses to Findings and Recommendations and is scheduled for release in May, 2012.

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: 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: 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.

Management and Operational Challenges

Beginning with this Report, and at least annually hereafter, the OIG will depart from its traditional format and prepare a report containing "a description of any significant problems, abuses, and deficiencies related to the management or operation of state agencies or nonstate agencies" serving individuals requiring behavioral health and developmental disability services and supports.[1]

The challenges identified in this section reflect both system vulnerabilities, as outlined in recent OIG reports, as well as new and emerging issues identified by DBHDS and the OIG. The following summary of management challenges will be discussed in greater detail in this Report: (The order of presentation does not reflect relative importance.)

THE DOJ *SETTLEMENT AGREEMENT*: During this reporting period, the Commonwealth and the U. S. Department of Justice reached a settlement regarding Virginia's compliance with the *Americans with Disabilities Act* (ADA) and as interpreted by the *Olmstead* decision. It was agreed that Virginia would provide services for persons with intellectual disabilities in the most integrated setting appropriate to meet an individual's needs, and that the state would pursue the goals of community integration, self-determination, and quality services. The ten-year *Agreement* requires an expansion of community-based ID waiver slots, strengthening quality and risk management systems, closing four of Virginia's five training centers, and additional appropriations to support these initiatives.

INCREASING SYSTEMIC ACCOUNTABILITY: The DBHDS lacks a broad-based and active centralized quality assurance system, and it has had difficulty recruiting and retaining an Assistant Commissioner for Quality Management and Development. The creation of a robust quality assurance system is a necessary ingredient if the DBHDS is to comply with the terms of the recent *Settlement Agreement* with DOJ and to implement the strategies agreed to in past OIG Reports.

INCREASING CRISIS INTERVENTION SERVICES: DBHDS's *Creating Opportunities Implementation Plan* observed that "too many Virginians do not have access to a basic array of emergency and crisis response services" and concluded that "a safety net of basic services is indeed widely available in Virginia, but just barely." During this semi-annual reporting cycle, the OIG documented that, while basic safety net services may be available to most citizens, safety net services were not accessible for 72 individuals who, despite meeting statutory criteria for temporary detention, could not be detained for their own safety because no private provider, or state operated facility, would admit them.

[1] *Code of Virginia* § 2.2-313 (Effective July 1, 2012) Reports.

CREATING AND SUSTAINING INDIVIDUALIZED AND PERSON-CENTERED SERVICES: The DBHDS has been instrumental in facilitating person-centered and recovery-oriented services for persons who receive services in both the facility and community-based systems of care. The Office of Developmental Services (ODS), in cooperation with other agencies, has led the resurgence of person-centered services in Virginia; however, person-centered and recovery-oriented services in the community are not as consistently developed and monitored as the services provided in the state facilities.

The increase in service providers during the last few years, combined with the anticipated expansion over the next decade in response to the DOJ *Settlement Agreement*, suggests important challenges keeping up with the demand to provide and monitor ongoing person-centered and recovery-oriented services.

THE EFFECTIVE USE OF STATE RESOURCES: A rebalancing of state system funds will be required for the DBHDS to satisfy its commitment to watch over the assets of the Commonwealth's system of care for persons receiving behavioral healthcare and developmental services.

A six-month review during 2011 of the barriers to discharge from state-operated facilities for persons deemed discharge ready determined that inadequate community-based supported housing was the primary barrier to discharge for scores of individuals.[2] The average annual cost of serving an individual in a state-operated facility is $214,000; while a conservative estimate for serving the people on the discharge ready list in the community is approximately $44,000 per year.

The Commonwealth could annually save approximately $170,000 (per person) if it served this cohort in the community rather than continuing to serve them in state facilities. As of May, 2012 there are at least 70 individuals who could reside in the community with appropriate community housing and this alone would save almost $12,000,000 annually in exchange for an estimated upfront expense of just over $3,000,000.

In addition, based on the 2011 findings of the DOJ in the state of New Hampshire, Virginia is at risk for a similar finding of noncompliance with the relevant aspects of the *Americans with Disabilities Act* (ADA) as interpreted in the *Olmstead* decision. This OIG study concludes that important aspects of Virginia's behavioral health system are analogous to those found objectionable by the DOJ in New Hampshire.

[2] *Review of the Barriers to Discharge in State-Operated Behavioral Healthcare Adult Facilities*, OIG Report No. 207-12 (April 25, 2012).

Challenge No. 1
The DOJ Settlement Agreement

On January 26, 2012, Virginia and the U. S. Department of Justice (DOJ) reached a settlement agreement. The *Agreement* establishes the necessary conditions for ensuring the Commonwealth's compliance with Title II of the *Americans with Disabilities Act* (ADA), 42 U.S.C. § 12101, as interpreted by the *Olmstead* decision.[3] In summary, the *Agreement* requires: (A copy of the DOJ *Settlement Agreement* is attached as Appendix A.)

> That, to the extent the Commonwealth offers services to individuals with intellectual and developmental disabilities, such services shall be provided in the most integrated setting appropriate to meet their needs. Accordingly, the Parties intend that the goals of community integration, self-determination, and quality services will be achieved."[4]

Significant components of the Agreement include:

- The expansion of community-based services, including the addition of 4,170 new ID waiver slots over the next 10 years.
- Strengthening both internal and external community-based quality and risk management systems
- Transitioning individuals currently served in the state-operated training centers to appropriate community settings with the ultimate goal of closing 4 of the 5 state facilities serving persons with intellectual disabilities.[5]

Under the terms of the 10 year-court enforced *Settlement Agreement,* it is the responsibility of DBHDS "to develop and provide" the creation of community services designed to support all qualified individuals with intellectual and developmental disabilities in the most integrated setting. Under the Agreement, the transition to a fully realized community based system of care will occur in concert with the closure of four training centers. Included in this plan is the development of ongoing opportunities for workforce realignment without a premature exodus of staff from the facilities.

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

[4] United States of America v. the Commonwealth of Virginia *Settlement Agreement* U. S. District Court, Eastern District of Virginia (January 26, 2012).

[5] http://www.dbhds.virginia.gov/Settlement.htm#Agree: Summary of *Settlement Agreement*

The success of this multifaceted endeavor depends on numerous variables. Many of the tasks associated with the increase in community capacity and the closure of the facilities requires close coordination between DBHDS and other agencies. Ongoing implementation and operational challenges include the magnitude, complexity, and newness of some of the proposed programs, such as crisis services for persons with ID and the establishment of an effective internal and external quality and risk management system; compressed implementation timelines; family and legal guardian opposition to the closure of the facilities; and marketplace dynamics.

Relevant Developments

The Secretary for Health and Human Resources forwarded a plan to the Chairs of the House Appropriations and Senate Finance Committees and to the Governor on February 13, 2012.[6] This plan provides a detailed rationale for the transition to a community based system of care beyond those identified in the *Settlement Agreement* and a current picture of community based services for persons with ID. In addition, the plan outlines proposed actions for accomplishing this task including the following:

- State Facility Projected Closure Timeline: SVTC in FY20I5, NVTC in FY20I6, SWVTC in FY20I8, and CVTC in FY2020.

- Improvements to the current discharge processes to ensure safe and effective discharges.

- Focus on families and staff at training centers to ensure they are informed about the current options available in the community.

- The retention of employees during the closure and transition process is identified as a high priority in order to assure continuity of services to the individuals served.

- The recognition that downsizing and eventual closure of four training centers cannot occur without complementary changes to the community-based system of services.

Information sharing regarding proposed plans is currently a primary focus of DBHDS. Members of the senior management team have visited each of the training centers and met with staff across all of the shifts. An updated information memorandum was forwarded to CSB ID Directors from the Assistant Commissioner for Developmental Services in March

[6] A copy of the Secretary's plan is appended hereto for convenience at Appendix B.

2012 that highlights responses to the most frequently asked questions about the *Settlement Agreement*, and DBHDS leadership completed a presentation to the Senate Finance Committee in April.

Area(s) for Future Focus

DBHDS is implementing and administering new programs as well as expanding established services involving millions of tax dollars. The Commissioner provided an update of funding established during 2012 as proposed by the Governor and by the General Assembly for the biennial budget for FY2013 and FY2014.[7] Budget highlights from the Commissioner's email, included the following:

1. The approved budget provides $30 million in FY13 to build on efforts from the 2011 Session designed to expand efforts to facilitate transition of individuals with [intellectual disabilities] from state training centers to community-based services and address the needs of individuals in the community waiting for services.

   > These funds will be deposited in the DBHDS operational budget rather than the Behavioral Health & Developmental Services Trust Fund. Budget language also directs that the unexpended appropriation as of June 30, 2012 in the Trust Fund, which was appropriated in 2011 for the expansion of community-based services shall be reappropriated and that with the approval of the Secretary of HHR and the Director of DPB these funds shall be transferred from the Trust Fund to the General Fund where they can be used for the purposes of complying with the agreement with the U.S. DOJ.

   From these amounts, the following waiver slots, which are identified in the *Settlement Agreement,* will be established:

   - Community intellectual disability (ID) waiver
     - *FY2012-2013 – 225 slots*
     - *FY2013-2014 – 225 slots*
   - Facility waiver
     - *FY2012-2013 – 160 slots*
     - *FY2013-2014 – 160 slots*

[7] Email to CO Staff dated April 23, 2012 – Budget Announcement

- Developmental Disability (DD)
    - *FY2012-2013 – 25 slots*
    - *FY2013-2014 – 25 slots*

2. Waiver slots added by the General Assembly

    - 225 additional community intellectual disability (ID) waiver slots in addition to those provided by the *Settlement Agreement*.

        - *75 slots in FY2012-2013 with an approved budget of $2,551,725 in general funds (GF) and $2,551,725 in non-general funds (NGF).*

        - *150 slots in FY2013-2014 with an approved budget of $7,645,763 (GF) and $7,645,763 (NGF.)*

    - 80 additional developmental disability (DD) waiver slots in addition to those provided by the S*ettlement Agreement*. The slots are targeted to reduce the current waiting list of 1,075

        - *This includes 25 slots in FY2012-2013 with an approved budget of $371,950 (GF) and $371,950 (NGF).*

        - *This includes 55 slots in FY2013-2014 with an approved budget of $1,193,900 (GF) and $1,193,900 (NGF).*

3. A 1% rate increase for personal care services of community waivers. This provides a one percent rate increase for personal care services provided under community-based Medicaid waiver programs effective July 1, 2012. Funding for personal care rates, which include respite and companion care, was reduced during the session.

        - The approved budget for *FY2012-2013 is $3,187,405 (GF) and $3,187,405 (NGF.)*

        - *The approved budget for FY2013-2014 is $3,527,562 (GF) and $3,527,562 (NGF).*

4. A 1% rate increase in congregate residential services. This provides a one percent increase in the reimbursement rate for congregate residential services.

    - *The approved budget for FY2012-2013 is $1,996,773 (GF) and $1,996,773 (NGF).*

    - *The approved budget for FY2013-2014 is $2,110,177 (GF) and $2,110,177 (NGF).*

The responsibility for defining the provisions of new and expanded services and/or monitoring the funding rests on many internal and external components to the overall system of care, including, but not limited to, the Secretariat of Health and Human Resources (HHS), the State Board, DBHDS, CSBs, private providers, Department of Medical Assistance Services (DMAS) and the OIG. Focusing on integrity in the new programs and expanded services is vital to ensuring that the services operate with economy and efficiency. It is essential that all partners identify and mitigate vulnerabilities to the successful completion of this endeavor by prioritizing oversight resources through the establishment of targeted timelines, quality indicators, and supportive data gathering and assessment through the establishment of outcome measures.

In broad strokes, the factors necessary to actualizing the DOJ *Settlement Agreement*, require DBHDS and its partners assure that data systems supporting the programs are scrutinized for accuracy and timeliness; that ongoing staff and provider training regarding new program implementation and expansion occurs throughout the transition and beyond; that systems for accountability, transparency, compliance and risk mitigation are developed and monitored by multiple oversight authorities; and efforts to provide stakeholders with clear information and guidance as decision-makers in the creation of the newly established community system of care occur regularly.

Challenge No. 2
Increasing Systemic Accountability

DBHDS lacks an active broad-based and centralized quality assurance system to rapidly identify and address system vulnerabilities prior to the implementation of new programs and initiating expanded services.[8] The medical director's position has been vacant for the past several years and is currently being served by a part-time acting director. In addition, DBHDS has had difficulty in recruiting and retaining a qualified individual to serve in the position of Assistant Commissioner for Quality Management and Development. This key position, which has been essentially vacant for 16 months, provides leadership for a number of strategic divisions in assuring an efficient and effective transition to a community-based system of care, including the Office of Risk Management, the Office of Licensing, Abuse and Neglect Investigations, Human Rights, Office of Quality Management and Information Technology. The CO Committee for Quality Management suspended meetings for a number of months awaiting a new Assistant Commissioner.

The outstanding OIG findings that DBHDS has failed to implement are reliant on the successful implementation of a systemic quality management committee, including the development of a scope of work expectations and guidelines for sole dental practitioners in the facility system, and the establishment of staff-to-person served ratios for the effective implementation of person-centered services designed to enhance community integration activities while individuals are institutionalized. This last element alone will provide system planners with crucial information as individual preferences are realized and could be integrated in any plan for transition to community-based services, particularly for those individuals who have resided in state-operated training centers for most of their lives.

Continued delays in establishing a centralized quality management program will result in programs being established without the corresponding potential areas of risk and quality monitoring being identified in advance of implementation. Community providers anecdotally reported to members of the OIG staff that they are concerned about the effectiveness of the newly developing crisis intervention services for persons with ID because the program has not had enough time to prove effectiveness and emergency admissions to state facilities are reportedly suspended except for the behavioral healthcare facilities, which in the past relied on the training centers for extended care once the person was stabilized.

[8] The *Comprehensive State Plan 2012-2018* (December 2011) identifies "Improve Department quality assurance and improvement processes" as a systemwide investment priority under the "Resource Requirements," Section VIII.

During other community visits for the upcoming OIG reviews of community providers, variations in quality plans were noted and the majority of plans are not designed to guarantee program integrity and the effective use of resources, but are focused on individualized measures required by the prevailing regulations. While steps are generally taken to identify critical injuries and abuse and neglect, the system is not fully designed to reduce preventable injuries and complications that can arise in the provision of care for the persons served, nor is it designed to address systemic concerns that might surface from community-based abuse and neglect investigations.

Internal oversight divisions are stretched to their limits and have traditionally been challenged in their efforts at keeping pace with the increase in service demands and provider expansion. The expansion in programming that will result from the *Settlement Agreement* alone will tax the system further. There will be additional need for increased monitoring of the provision of human rights with the proposed "double-bunking" of persons served in the state's facility for sex offenders, the implementation of increased behavioral healthcare services, and potential on-going decrease in the availability of private psychiatric beds because of market forces.

Relevant Developments

DBHDS has outlined the importance of establishing a state-wide quality assurance and improvement system as part of the S*ettlement Agreement* with the DOJ. This recognition was outlined in the transition plan submitted to the Governor and Chairs of the House Appropriations and the Senate Finance Committees in February 2012. The plan highlights the need for additional oversight and monitoring staff, including licensure specialists, human rights advocates, and community resource consultants. Data management specialists will be needed to collect data and track outcomes for the persons served in areas such as safety, health, and well-being. DBHDS has been actively recruiting and filling a number of positions needed for the implementation of a state-wide community based quality management system, as appropriate.

Another key component identified in the transition plan will be the establishment of regional quality councils. These councils will be comprised of a variety of stakeholders with varied skills and interests regarding quality care. It is projected that the councils will meet at least quarterly and will receive guidance from the DBHDS Quality Improvement Committee.

Onsite monitoring by licensing specialists and case managers will be a priority with a focus on actively checking on "high-risk individuals on a monthly or more frequent basis to ensure their needs are met and they are not experiencing unnecessary risk. Those individuals who are high-risk include those receiving services from a provider with a conditional or provisional license, those with high medical or behavioral needs, those with frequent crises

or interruptions in service, those who have recently transitioned from training centers, and those residing in congregate settings of 5 or more individuals."[9]

The *Creating Opportunities Implementation Report, Update March 2012* outlined a number of accomplishments, implementation activities, and planning milestones, but provided very little information on the development of quality indicators in which to measure program integrity or service provision outcomes.

Area(s) for Future Focus

The development of a viable state-wide quality assurance system serves as a pledge to the public that the various components that comprise the behavioral health and developmental services system of care will work towards the goal of achieving optimal excellence in the services rendered to all qualified persons. As stewards of the state's limited resources, it is an obligation of agencies, such as DBHDS, to hold themselves accountable to the public for the caliber of care they provide. Implementation of a quality assurance/improvement program involves the development of criteria based on acceptable standards of care and norms. Establishing outcome criteria for divisions serving the system as well as each program are a necessary first step. While this activity is initiated for many of the programs already in existence, there has not been a uniform set of norms or criteria established system-wide that assures performance enhancement at all levels of care. While retrospective and concurrent quality reviews do occur in many areas, particularly those typically associated with risk management, such as injuries, abuse and neglect and deaths, the knowledge gained is not always reviewed in the aggregate and, as a result, does not generate performance improvement initiatives across the system. Lessons learned in one setting are rarely communicated within similar settings.

DBHDS maintains many databases that are primarily designed to provide statistical information associated with particular programs, areas of risk, or system vulnerabilities. It will need in the coming months to adapt the databases to assure that the system is not only capturing "what actually is occurring" but what "should be occurring" so that enhancements to the system can occur on a regular basis.

The DOJ *Settlement Agreement* serves as a catalyst for the enhancement of state-wide quality assurance initiatives, but quality assurance initiatives in others service areas are just as vital to the overall effectiveness of the organization. DBHDS needs to prioritize quality of care and the safety of persons served, by building on past efforts, while enhancing quality

[9] Transition Plan submitted by the Secretary of Health and Human Services to the Governor, and the Chairs of the House Appropriations and the Senate Finance Committees on February 13, 2012, page 11.

improvement provisions for goals delineated in the Creating Opportunities Plan and strategic recommendations established through the various workgroups.

The OIG recommends that DBHDS generate and post outcome criteria with progress in evaluating and measuring success, and that the outcome of these activities be published at least every six months. The publication of quality management reports increases accountability and transparency regarding the use of state resources and serves as a "yardstick" for measuring accomplishments in system transformation. The six month reporting timeframe is consistent with the time established through the S*ettlement Agreement* for reports to be submitted to the court by the independent monitor regarding the state's compliance with the terms agreed upon in the document. By using the same timeframes for reporting, DBHDS will increase the likelihood that it avoids a bifurcated quality management system.

Challenge No. 3
Increasing Crisis Intervention Services

DBHDS defined this challenge in the Creating Opportunities Implementation Plan issued in July 2011. The plan outlines the following:

> Even with recent initiatives to establish crisis stabilization services, too many Virginians do not have access to a basic array of emergency and crisis response services and are involuntarily hospitalized and incarcerated, the most restrictive and costly options available. This could be reduced by increasing access to emergency and crisis response and diversion services, implementing recovery-oriented crisis response practices, and managing intensive services more consistently.

An inventory of available emergency services throughout the state was updated in 2011 by the Emergency Response Strategic Initiative Team, a group developed as a part of DBHDS' *Creating Opportunities* initiative.[10] The team's final report noted the following:

> The survey results show that despite the widespread availability of most baseline services, **insufficient access and capacity are still problematic**. In addition to the general lack of availability of psychiatric evaluation and medication administration within 24 hours and psychiatric crisis consultation, survey respondents also reported the highest priorities for capacity building in the inpatient, residential crisis stabilization, and detox service categories - services that are already widely available. Comments submitted by many CSBs indicate that timely access to available services is further hampered by geography, lack of transportation, special needs of certain individuals or populations (e.g., elderly persons, persons with co-occurring medical conditions, etc.), and other complicating variables. **Taken together, these findings indicate that a safety net of basic services is indeed widely available in Virginia, but just barely.** Despite the availability of basic services, behavioral health providers and other emergency service partners are severely challenged every day to access services for the variety of people they serve. [Bold by OIG]

[10] Creating Opportunities Emergency Response Team Final Report, July 27, 2011

Increased crisis intervention services for both adults and children have been identified as priorities by DBHDS leadership including specialized crisis intervention services for certain targeted populations, such as persons with intellectual disabilities, the elderly, and as a tool to maximize jail diversion.

In a report issued by the OIG during this semi-annual reporting cycle, it was documented that while basic safety net services may be available to most citizens, safety net services were not accessible for 72 individuals who, despite meeting statutory criteria for temporary detention,[11] could not be detained for their own safety because no private provider, or state operated facility, would admit them.[12] The 90 day study showed that for each incident, in which a person is denied the level of services determined by trained mental health professionals to be clinically necessary, represents a failure of the system to address the needs of that individual at the time of crisis and places the individual, his family, and the community at risk.

Relevant Developments

In its response to the aforementioned unexecuted TDO report, DBHDS indicated its support to the development of several quality improvement initiatives recommended by the OIG. The agency's compliance with the recommendation will be monitored and reported on every six months until the agreed upon outstanding recommendations are resolved. Among the recommendations for which DBHDS indicated its support in accomplishing are the following:

- That unexecuted TDOs and emergency services events that extend beyond 6 hours after being initiated become quality indicators that are tracked at the CSB level and regionally.

- That DBHDS include a provision in its next *Performance Contract* with the CSBs requiring specific local or regional monitoring of problems identified with medical screening and clearance for persons meeting ECO and TDO criteria and report the results at regular intervals. In addition, the state facilities will develop best practice criteria for monitoring quality improvement in the areas of medical screening and medical clearance expectations that are consistent with practice norms.

[11] Pursuant to §37.2-808 B. a person meeting criteria for a TDO must have been determined to"…(i) has [have] a mental illness and that there exists a substantial likelihood that, as a result of mental illness, the person will, in the near future, (a) cause serious physical harm to himself or others as evidenced by recent behavior causing, attempting, or threatening harm and other relevant information, if any, or (b) suffer serious harm due to his lack of capacity to protect himself from harm or to provide for his basic human needs, (ii) is in need of hospitalization or treatment, and (iii) is unwilling to volunteer or incapable of volunteering for hospitalization or treatment."

[12] OIG Report #206-11: *A Study Examining Unexecuted Temporary Detention Orders (TDOs) in the Commonwealth*, February 2012

- That DBHDS establish a quality improvement initiative for monitoring TDO admissions to the state-operated behavioral health facilities with periodic reporting to the Commissioner and the OIG

Each of these agreed upon recommendations is consistent with DBHDS' overall emergency response services goal to "strengthen the responsiveness of behavioral health emergency response services and maximize the consistency, availability, and accessibility of services for persons in crisis",[13] and the OIG looks forward to working with the department to successfully resolve these outstanding recommendations. Another accomplishment of DBHDS is the recent hiring of a crisis intervention community support specialist. This Central Office position will serve as lead staff for crisis intervention and emergency response services and can support the resolution of these recommendations.

In response to the DOJ S*ettlement Agreement* process, DBHDS contracted with Dr. Joan Beasley from the University of New Hampshire to consult on the development of the START[14] crisis response model for use across Virginia for persons with intellectual disabilities. The development of a statewide ID/DD crisis response system is scheduled for implementation by June 30, 2012. This will include crisis hotlines, mobile response teams and the establishment of at least one crisis stabilization program in each region across the state. Crisis support plans will be generated prior to discharge from the state-operated training centers so that all parties understand options for accessing needed services. This is the first comprehensive crisis response system developed by the department to meet the specialized needs of this population. Even though the program is too new to Virginia to measure its effectiveness to divert this population from unnecessary inpatient services, it has been successfully implemented in other states. This model, which is specifically designed to address the crisis response needs of this population, is very promising.

Funding has been allocated to areas that will support community based crisis response services.[15] These include the following:

1. *Funding for child psychiatry and children's crisis response*

    a. *FY2012-2013 – $1,500,000 GF and FY2013-2014 – $1,750,000 GF*

[13] *Creating Opportunities Implementation* Report. Update March 2012, page 1.

[14] START (Systematic, Therapeutic, Assessment, Respite and Treatment) is a linkage model to promote a system of care in the provision of community services, natural supports and mental health treatment to people with intellectual and developmental disability and mental health issues (IDD/MH), Beasley, Joan. Institute on Disability. University of New Hampshire. 2002

[15] Email to CO Staff dated April 23, 2012 – Budget Announcement

This allocation provides funding for child psychiatry and children's crisis response services. Funds are to be utilized among the health planning regions based on the current availability of services with a report on the use and impact of funding due annually beginning in 2013.

2. *The development of up to 5 drop-off centers on jail diversion programs*

    a. *FY2012-2013 – $600,000 GF and FY2013-2014 – $600,000 GF*

These funds are to be used to expand capacity for up to five drop-off centers to provide an alternative to incarceration for people with serious mental illness by ensuring prompt assessment and appropriate treatment for individuals picked up by local law enforcement officials. Funding will be targeted to programs that have implemented crisis intervention teams and have undergone planning to implement drop-off centers.

3. *The allotment allows DBHDS to keep 13 beds open at Northern Virginia Mental Health Institute (NVMHI)*

    a. *FY2012-2013 – $600,000 GF*

This allocation provides funds to continue operating beds that were proposed for closure two years ago as a result of budget reductions at NVMHI. Budget language is added requiring a report on a long-term plan to ensure adequate bed capacity is available to serve individuals who require an inpatient bed for the treatment of acute mental illness.

Area(s) for Future Focus

Crisis intervention services tailored to meet the needs of other specialized populations such as children and their families as well as the elderly are minimal. As with the ID population, crisis supports and services need to be designed in a way that provides for the unique treatment and safety needs for these populations, while maximizing their natural support systems and limiting the unnecessary disruptions in their lives that often occurs when extended inpatient stays are the only option. Limited funding has delayed the significant development of individualized alternative crisis services for these specialty groups.

Inadequate oversight and quality assurance services regarding crisis support needs for these populations either do not exist or are insufficient for effective planning and program implementation. Monitoring that confirms that each person served is receiving the appropriate level and type of service necessary to address their needs is vital to program integrity and effectiveness.

Challenge No. 4
Sustaining Individualized, Person-Centered, Recovery Oriented Services

DBHDS has been instrumental in facilitating person-centered and recovery oriented services for persons who receive services in both the facility and community based system of care. However, person-centered and recovery oriented services in the community are not as consistently developed and monitored as the services provided in the state facilities, particularly within the growth and expansion of providers of services experienced in the last few years and anticipated over the next decade.

Keeping up with the demand to provide ongoing person centered and recovery oriented services as new providers come on line, while sustaining and refining these same services over time is the primary challenge facing both the system and providers. Assuring that person centered and recovery oriented services and supports are actually individualized and tailored to address activities and goals that are both important to and for persons served require more extensive oversight and monitoring than is available currently.

Relevant Developments

The Office of Developmental Services (ODS), in cooperation with other agencies, has assertively led the resurgence of person-centered services in Virginia. ODS provides extensive training opportunities for community settings in person-centered thinking and planning. Ongoing training includes training in person centered thinking, and both basic and advanced training regarding the development of person centered individualized services and support plans. Members of the OIG staff attended trainings in both person-centered thinking and planning during this semi-annual reporting period.

While a more systemic approach to recovery oriented training is less prevalent, limited community based measures, particularly within the CSBs occurs. For the last two years, the results, of the ROSI (Recovery Oriented Systems Indicator) survey by the CSBs, have been posted on the department's website. This provides an overall measure of the individuals' surveyed beliefs regarding the services received.

Area(s) for Future Focus

Developing synergy for advancing a person-centered and recovery oriented culture requires a continual commitment of DBHDS and provider leadership. A provider workforce trained in person-centered thinking and planning is essential to advancing the desired cultures in settings that support individuals needing intellectual, developmental and behavioral health

services and supports. That culture is at the core of the DOJ *Agreement* for individuals with intellectual and developmental disabilities and the planned shift to an “at risk” model for Medicaid behavioral health services will require providers to be even more adept at developing person-centered interventions.

The current “opt-in” approaches to training in person-centered thinking and planning will not create systemic transformation in the rapidly expanding and changing provider network. A requirement for provider training will necessitate additional training resources within DBHDS and the commitment of provider leadership to develop internal coaches or mentors to support this culture on an ongoing basis.

Alignment of practices is essential to advancing a person-centered culture. They must be continually reviewed and refined as needed so they work well together and push in the same direction. DBHDS and providers will need to integrate measures that evaluate efforts to advance person-centered cultures into their continuous quality improvement policies and procedures.

Challenge No. 5
The Effective Use of State Resources

The DBHDS is committed to protecting the assets and the interests of the Commonwealth's system of care for persons receiving behavioral healthcare and developmental services, and to deploying the Commonwealth's limited resources in the most effective and efficient manner.[16]

Maintaining individuals in institutional settings who could be served in more integrated community settings, at less cost, is counter to the principles espoused in Title II of the Americans with Disabilities Act (ADA), 42 U.S.C. § 12101, and in the *Olmstead d*ecision*, (Olmstead v. L.C.*, 527) and inconsistent with the Governor's emphasis in assuring efficient and effective management of public funding. During this six-month reporting cycle, the OIG completed a review of barriers to discharge for persons confined to behavioral healthcare settings after their professional teams determined they were clinically ready for discharge.

Inadequate supportive housing was cited as the primary barrier to discharge for the persons reviewed by the OIG. Limited community capacity to serve all individuals in the most integrated setting hampers efforts by DBHDS to assure the most effective use of state resources. Unfortunately, this is not a new problem for Virginia, as our research confirmed that inadequate supported housing has been a significant systemic issue for over a decade.

The average annual cost of serving an individual in a state-operated facility is $214,000;[17] while a conservative estimate for serving the people on the discharge ready list in the community is approximately $44,000 per year. The Commonwealth could annually save approximately $170,000 (per person) if it served this cohort in the community rather than continuing to serve them in state facilities. As of April, 2012, there are at least 70 individuals who could reside in the community with appropriate community housing and this alone would save almost $12,000,000 annually in exchange for an estimated upfront expense of just over $3,000,000.[18]

[16]DBHDS website "Stewardship": http://www.dbhds.virginia.gov/CO-MissionValues.htm.

[17]*Major Issues Facing the Commonwealth's Behavioral Health & Developmental Services System*, January 13, 2011.

[18]*Review of the Barriers to Discharge in State-Operated Behavioral Healthcare Adult Facilities*, OIG Report No. 207-12 (April 25, 2012).

Relevant Developments

OIG Report No 207-12 profiled that there was “an average of 165 adults on the extraordinary barriers to discharge list (EBL) from July through December 2011, and, on average this population has been discharge ready for almost eight months,” and that “each individual that remains on the EBL for an extended period diminishes the state’s capacity to provide needed safety net services for individuals in acute crisis meeting the criteria for temporary detention (TDO).”

The six-month study supported a finding that “the primary barrier throughout the Commonwealth to the timely discharge of clinically ready individuals is the lack of permanent supported housing.”

Area(s) for Future Focus

The OIG Report recommended that the each region create an extraordinary barriers to discharge list and publish quarterly updates. Publically tracking the state’s performance will provide a metric to measure the state’s progress in managing this chronic problem.

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, 343 critical incidents related to injuries and other areas of risk were reported to the OIG through the PAIRS database. Of these incidents, 166 (48%) incidents occurred in the state-operated training centers and 177 (52%) occurred in the state-operated behavioral health facilities. The OIG reviewed each of the 343 critical incident reports forwarded by DBHDS with an additional level of inquiry and follow up conducted on 58, or 17% 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.

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 38 deaths in the state-operated facilities from 10/1/11 to 3/31/12; 14 of the deaths occurred in the training centers and 24 deaths were reported in the behavioral health facilities. All of the 26 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, 11 were complaints/concerns and 9 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, policies and plans:

State Board Policies

Policy 2011(ADM) 88-3	Naming of Buildings, Rooms and Other Areas at State Facilities
Policy 3000(CO) 74-10	Department Employee Appointments to Community Services Boards
Policy 5006(FAC) 86-29	Razing of Dilapidated Buildings
Policy 5008(FAC) 87-12	Accreditation/Certification
Policy 7000(INTER) 85-4	Department/University and College Relationship
Policy 1028 (SYS) 90-1	Human Resource
DRAFT Policy 1044 (SYS)12-1	Employment First
Policy 1016 (SYS) 86-23	Policy Goal of the Commonwealth for a Comprehensive Community-Based System of Services
Policy 1034 (SYS) 05-1	Partnership Agreement
Policy 1036 (SYS) 05-3	Vision Statement

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 presentations regarding the work of the office or served as the guest speaker:

- Joint Commission on Healthcare
- Presentations to various regional CSB organizations

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

- VACSB Fall Conference
- Ethnicity, Culture and Alcohol – National Institute on Alcohol Abuse and Alcoholism
- America's Children: Key National Indicators of Well-Being, 2011 Federal Interagency Forum on Child and Family Studies
- Ethics for Professional Counselors
- Person-centered thinking sponsored by DBHDS.

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:

- Community Services Boards and their Regional Management Meetings

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
- CSB Emergency Services Directors
- Medical Directors, various hospital Emergency Departments

REPORTS ISSUED THIS REPORTING PERIOD INCLUDING FINDINGS AND RECOMMENDATIONS

OIG Report No. 199-11: *OIG Inspection of the Commonwealth Center for Children and Adolescents*

OIG Finding No. 1: There has been a significant increase in admissions to CCCA over the past two fiscal years. There were 780 admissions in FY11, which represented a 38% increase over the previous fiscal year.

No Recommendation

OIG Finding No. 2: Limited community treatment services and inadequate capacity contribute to the increasing admissions, recidivism rate at CCCA and often contributes to delayed discharges.

OIG Recommendation No. 2a**:** It is recommended that DBHDS secure funding to create secure specialized community based crisis stabilization services for children and adolescents as a first tiered strategy for diverting appropriate emergencies situation to a less restrictive and more normalized setting within the child or adolescent's home community.

DBHDS Response No. 2a: *As part of its strategic planning activity, "Creating Opportunities," and in compliance with Item 304.M, DBHDS completed a comprehensive assessment of children's mental health services needs. This process identified crisis stabilization services among the highest priorities for development of expanded children's mental health services and recommended funding specific initiatives for these services. The plan was reviewed by the Secretary for Health and Human Resources and was submitted to the General Assembly on October 24, 2011. Staff from CCCA participated in the development of this plan. Since then, DBHDS sought and has received a SAMHSA System of Care Expansion grant to continue to promote and develop the opportunities documented in the children's services plan. CCCA also participates in the System of Care Expansion grant leadership committee. Securing funding for a system of crisis stabilization services for children is a high priority for the DBHDS.*

OIG Recommendation No. 2b: It is recommended that DBHDS and the community services boards work in concert with DJJ and other correctional settings to identify and respond to the mental health needs of juveniles in community based programs and institutions by providing appropriate clinical capacity to conduct evaluations and support the growth of clinical expertise in juvenile justice programs. Future admissions need to be grounded in arrangements that require that each agency understand and respect the others' purposes and missions.

DBHDS Response No. 2b: *DBHDS agrees that improved mutual understanding of agency purposes, missions, and capabilities will improve interagency cooperation to better meet the needs of youth with challenging behaviors. DBHDS and CCCA began a dialogue with DJJ in the summer of 2011 following the referral of a number of children who presented challenges of safety and inappropriateness for treatment at CCCA. After this dialogue there have been no inappropriate referrals. CCCA and DBHDS will maintain and expand the dialogue with DJJ on a continuing basis. The goal of this process will be to improve the agencies' mutual understanding of their respective missions, programs, and capabilities and to forge a cooperative, mutually supportive relationship that meets the needs of children in the juvenile correction system at the most appropriate, safest sites, which is usually in the DJJ facilities. The Department will continue to monitor referrals and relationships between DJJ and CCA and provide a progress report to the OIG in the next update to this report.*

With funds provided by the General Assembly, CSBs now provide onsite mental health services at all juvenile detention sites in Virginia. DBHDS attends all quarterly meetings of the Juvenile Detention Superintendents to promote quality communication and problem solving.

OIG Finding No. 3: CCCA is not designed by its unit structure and physical configuration to effectively manage the treatment needs of diverse populations.

OIG Recommendation No. 3: In order to support creating and maintaining a trauma-informed environment of care, it is recommended that CCCA and DBHDS work together to address the current limitations produced by the facility's unit structure and physical environment by examining the facility's complement of staff and use of space, particularly as it pertains to the distinct and often counter-therapeutic needs of the diverse populations served.

DBHDS Response No. 3: *CCCA leadership has evaluated the feasibility of redesigning the physical environment as a means to reduce risk to patients and staff. Greater specialization and separation of spaces for specific populations will introduce unintended consequences for staffing needs and may reduce the facility's need for flexibility to accommodate unpredictable combinations of admissions with diversity of gender, age, and risk to others. Of greater promise is increased funding to vary staff-to-patient ratios on a flexible basis among units and over time, depending on admissions.*

DBHDS leadership at the Assistant Commissioner, Deputy Commissioner, Commissioner, and Secretary of HHR have interacted directly and in detail with CCCA leadership and staff around the complex issues presented by the changing population of children served at CCCA. CCCA leadership has presented staffing and budgetary options which have been given careful consideration during the process of developing plans and priorities for future budget and program development.

OIG Finding No. 4: The facility's current staff to resident ratio does not align with its new supervisory structure for providing effective trauma informed care for this increasing clinically challenging treatment environment.

OIG Recommendation No. 4: It is recommended that CCCA review all staffing positions to assess whether the current ratios allow for maximum treatment effectiveness. Positions that would enhance security, increase direct care contact with the children served and support the provision of trauma informed care should be the priorities.

DBHDS Response No. 4: *As stated above with regard to Recommendation No. 4, DBHDS leadership at the Assistant Commissioner, Deputy Commissioner, Commissioner, and Secretary of HHR have interacted directly and in detail with CCCA leadership concerning the facility's needs for increased staffing and changes in staff roles. CCCA leadership has presented staffing and budgetary options which have been given careful consideration during the process of developing plans and priorities for future budget and program development. DBHDS will reassess staffing needs and available resources following the upcoming General Assembly session and provide an update in the next report.*

OIG Finding No. 5: Paperwork demands are inconsistent with the facility's current mission and model.

OIG Recommendation No. 5: It is recommended that CCCA continue working with DBHDS leadership to explore potential waivers or alternatives to the current documentation requirements so that the focus of service provision is on the individualized needs of the residents.

DBHDS Response No. 5: *DBHDS agrees that the pace and frequency of admissions and discharges have changed significantly since the policies and practices for documenting care and needs were developed for CCCA. DBHDS, including the Office of Licensure, will work with CCCA leadership to develop opportunities to streamline documentation, reduce paperwork, and eliminate redundancy where possible. CCCA has specific items which it will organize and submit to DBHDS within the first quarter of 2012. DBHDS's development of the electronic medical record will also help address these issues.*

OIG Finding No. 6: CCCA has instituted a number of practices that have reduced the use of seclusion and restraint while enhancing the provision of trauma-informed

No Recommendation

OIG Finding No. 7: The use of seclusion and restraint in the facility is significantly impacted by the number of admissions, average lengths of stay, and staff to resident ratios.

OIG Recommendation No. 7: It is recommended that CCCA, in coordination with DBHDS, establish targeted quality improvement initiatives designed to further evaluate the correlations between seclusion and restraint usage and the identified contributing factors.

DBHDS Response No. 7: *CCCA will address this recommendation with the DBHDS utilizing data found in the Seclusion/Restraint database as well as benchmarks from other child serving public facilities.*

OIG Report No. 200-11: *OIG Review of Behavioral Health Forensic Services*

OIG Recommendation No. 1: That DBHDS establish a team comprised of individuals with recovery and person-centered expertise to recommend how best to create a more integrated recovery and person-centered experience for individuals treated in forensic programs. Given their current leadership role and expertise in person-centered thinking and planning, it is recommended that the team include representation from the Office of Intellectual Disabilities or individuals recommended by that office.

This recommendation is linked to seven findings:

- Finding No. 3: To a large degree, efforts are made to elicit and incorporate the individual's own words in the treatment plan, however, the methodology varies from facility to facility and individual input is generally recorded on a separate form.
- Finding No. 7: Treatment planning documents include individualized goals for treatment that will help the individual move out of the facility and enjoy a satisfying, good life in the community. This documentation often occurs on separate forms that the facilities have developed as addendums to the primary treatment plan, which generally reflects a more standardized treatment that is linked to one of the five forensic categories noted in this summary.
- Finding No. 8: Treatment planning documents reflect efforts to provide individuals with services and supports that address a wide variety of life/skill needs. This documentation tends to be in separate addendums to the formalized treatment plan, which generally reflect a standardized treatment linked to one of the five forensic categories noted in this summary.
- Finding No. 9: Treatment planning documents relate to a wide variety of life skill/need areas, showing a holistic view of the person, rather than a focus only on symptoms and behavior changes. This documentation tends to be in separate addendums to the formalized treatment plan, which generally reflect a standardized treatment linked to one of the five forensic categories noted in this summary.
- Finding No. 15: The medical records of individuals served at facilities are using person-first language that is non-stigmatizing, non-labeling. There use of directive language exists in many records, often linked to treatment expectations for individuals that are receiving services and supports pursuant to an NGRI admission. The use of "patient" is

present in many records, but there is also use of the individuals name or a reference to "this individual". Record entries in the last several years show increased reliance on person-centered language.

- Finding No. 31: Person-centered language was present in forms, but the use of traditional language for referring to the individual that is receiving services and supports remains fairly common in record documentation. Additionally, while new forms include references to "shared goals" or a treatment "partnership", the new recovery oriented forms tend to still place a sole emphasis on treatment provided by staff and give little ownership to the individual that is receiving the services and supports. This may reflect the distinction between DBHDS efforts to promote recovery values and the more specific personal actions and behaviors that are the focus of person-centered training and education.
- Finding No. 32: The recommendations are specific to addressing perceived systemic challenges. There are no recommendations that appear to address the options for more recovery and person-centered services indentified during the OIG staff interview of facility forensic leaders. (The July 25, 2011 DBHDS posting of "*Creating Opportunities Implementation Plan: Identifying the Priorities and Actions Needed*")

DBHDS Response to No. 1: *DBDHS concurs with the OIG recommendation that recovery and person-centered principles are an important component of documentation and recovery planning activities. DBHDS has committed to continuing and expanding the comprehensive review of forensic services and needs that was initiated in the Creating Opportunity strategic planning process in FY11. This effort will resume after the 2012 General Assembly session. This review will also address enhancement of the person-centered experience for individuals treated in forensic programs. DBDHS has facility and central office forensic and behavioral health staff that have strong expertise in and commitment to person-centered recovery planning and service delivery. Direct participation of persons with lived experience in forensic services is also a part of our approach. DBHDS has already started dialogue on this topic with peer support and consumer leaders, building on meetings held in the summer of 2011 and continuing this fall and winter. DBHDS' annual peer review of its mental health facilities, the Annual Consultative Audit, will address recovery and person-centered aspects of all facility services, with a section on forensic services, and will involve teams of peer support staff from other facilities. These reviews will commence in the spring of 2012.*

The DBHDS provide an update of progress in this area by July 1, 2012.

OIG Recommendation No. 2: That DBHDS utilize the recommended team or another process of their choice to identify treatment planning and record documentation activities that could be standardized in support of the individual having a person-centered recovery experience.

This recommendation is linked to two findings:

- Finding No. 29: In past OIG reviews it has been noted that each facility had developed their own system for record management and treatment documentation. The forensic review confirmed that "home grown" is still the norm. This approach offers both challenges and opportunities. It is challenging for a reviewer to start anew with each facility and it may be confusing to individuals that move from facility to facility during the conditional release process. There does not appear to be any system-wide structure that allows for any "best-practice" models to be identified. If that structure were to exist, there is an opportunity for these best practices to be replicated.

- Finding No. 30: Several practices were noted during the reviews that reflect a facility level commitment to advancing person-centered treatment. In many instances facilities have adapted forms to reflect a more recovery and person-centered philosophy, including ensuring input from the individual in service planning and reviews.

DBHDS Response to No. 2: Achieving Greater Uniformity Among Facility Forensic Programs: *A component of the comprehensive review of DBHDS' forensic programs will include efforts to bring about a higher degree of standardization In the operation of forensic services among the various facilities, where such standardization is useful and appropriate. The new DBHDS Director of the Office of Forensic Services, effective January 10, 2012, will have responsibility for reviewing practices and policies among the facilities and recommending improvements in standardization of the experience and opportunity for persons receiving these services.*

Record Documentation: *DBHDS is currently in the process of moving toward the implementation of an electronic health record. Staff from the Forensic Office participates on the workgroup that is assigned to review documents, and provide guidance, regarding the development and implementation of an electronic health record. Representatives from the Office of Intellectual Disabilities also serve on the workgroup. One impact of an electronic record is the inherent standardization of forms that is required. Among the elements the workgroup considers in identifying forms that are appropriate for an electronic health record are forms that simultaneously meet the standardization and reporting requirements associated with an electronic health record that supports person-centered planning. This is an ongoing project.*

Treatment Planning: Each facility's Forensic Coordinator participates in periodic meetings where best practices within forensic psychology/psychiatry are reviewed and discussed. DBHDS' contractual relationship with the University of Virginia's Institute of Law, Psychiatry and Public Policy provides ongoing opportunities for DBHDS staff and our Community Service Board partners to stay informed about current trends and empirically-based best practices within the field of forensic psychology/psychiatry including person-centered recovery activities and treatment planning.

Departmental Instruction 111(TX) 01, which applies to all DBHDS facilities, delineates a specific framework and expectations regarding the treatment planning process. This Department Instruction explicitly allows for the integration of additional assessments,

assessment elements or assessment procedures as long as they do not conflict with the requirements of the DI. This DI also establishes the expectation that the treatment planning process must be client centered, and to the extent possible be inclusive of the client's input and preferences.

As stated above, the advancement of improved and more standardized treatment practices are to be addressed by both the comprehensive review of the system of forensic services and the creation of a new position for Director of Forensic Services.

OIG Recommendation No. 3**:** That DBHDS work with CSB leadership to increase the frequency of engagement of CSB staff with individuals in facilities pursuant to any forensic code and that level of engagement is monitored through the on-line secure site discharge planning system.

This recommendation is linked to two findings:

- Finding No. 6: A family member, friend, CSB representative, or another advocate attends treatment-planning meetings; however the frequency of such participation varies considerably. The OIG focused on treatment planning meetings over a twelve-month period preceding the review date.
- Finding No. 16: Forensic leadership is encouraged by and support current DBHDS efforts to more fully align facility and community-based services. Leaders repeatedly emphasized the importance of CSB staff being more aware of forensic services, especially the NGRI process; engaged during the treatment episode; and developing more transitional residential options.

DBHDS Response to No. 3: *DBHDS staff continuously work to improve opportunities for CSB staff to be actively engaged in the discharge planning process for all forensic consumers. CSBs currently work with forensic consumers while the consumer is in jail, continue their engagement while the individual is hospitalized, and via the discharge planning process continues with their involvement once the individual is discharged. For some forensic consumers the CSB is limited by the realities of the legal process in their ability to provide ongoing discharge planning, planning that would ordinarily be utilized to plan for the consumer's return to the community. DBHDS agrees greater utilization and monitoring of the secure on-line discharge planning system could facilitate the Department's ability to identify trends and areas of needed improvement in the discharge planning process. DBHDS will develop a process of utilizing the secure discharge planning site to actively monitor the CSBs engagement with the discharge planning process and protocols.*

Current forensic policy requires the input of a NGRI acquittee's CSB at every level of privilege involving access to the community, which is currently 6 out of 7 privileges levels. It is rare that CSB staff do not meet with individuals in forensic programs multiple times throughout the acquittee's participation in the graduated release program. At the level of unescorted community visits acquittees are expected to meet face to face with their CSB

case manager on an ongoing basis in order to further establish the working relationship that will be necessary during an acquittee's.

Other categories of individuals involved in the forensic process vary with regard to whether they require or want face to face contact with CSB staff. For those individuals involved in the forensic process that require or request CSB involvement, face-to-face engagement is expected, however at this point no set number of face-to-face contacts has been prescribed. Efforts will be made to improve documentation in the clinical record of these activities.

As stated above, the advancement of improved and more standardized treatment practices are to be addressed by both the comprehensive review of the system of forensic services and the creation of a new position for Director of Forensic Services. Progress on these activities will be reported in the next update to this report.

OIG Recommendation No. 4**:** That DBHDS work with CSB leadership to promote a better understanding of the conditional release process, specific to the manner in which the privileges earned by individuals directly reflect their ownership and management of their mental illness.

This recommendation is linked to two findings:

- Finding No. 17: The structure of the legal process that drives forensic services creates unique challenges for the staff in forensic services, as clinical decision making on readiness for discharge is dependent on approval by forensic review panels and ultimately, a judge. As such, the treatment staff and the individual they are treating, share a common experience of having to prove the success of their treatment partnership.

- Finding No. 20: Forensic leadership identified factors that create barriers to forensic services being more aligned with values recovery and person centered values, especially for the NGRI population.
  - *"The CSB staff don't understand how much our patients accomplish over many years and they still think of them as criminals."*
  - *"To often the NGRI label is identified as The Barrier to discharge to the community."*

DBHDS Response to No. 4: *The Code of Virginia specifically requires the CSB to collaborate in the development of a conditional release plan for all NGRI acquittees. The 2003 NGRI Manual specifically includes the CSB as a partner in the management of privileges within the NGRI graduated release process. CSB staff are routinely informed of scheduled treatment plan meetings. Additionally, the signature of CSB staff is required on risk management plans that allow an aquittee to have access to the community. By affixing their signature the CSB is indicating that it is aware of the level of privilege under consideration, the risk management and recovery issues of concern, and that the CSB will*

provide the services stipulated in the plan. In all instances risk management plans are the result of collaboration between the consumer, facility and CSB. Forensic Services convenes quarterly meetings with each of the CSBs in the Commonwealth, these meetings provide a forum that allows CSB staff to discuss person-centered planning opportunities for consumers, as well as ongoing training on all aspects of the conditional release process. Through their participation in the privileging process CSB staff have the opportunity to facilitate forensic consumers in demonstrating their ability to take ownership of their recovery through incremental increases in privilege and responsibility. More recently CSB Directors have begun attending the quarterly meeting. DBDHS agrees that greater understanding of the relationship between the privileging process and recovery principles by CSB leadership will enhance the recovery experience for consumers under forensic status. DBDHS will continue to encourage CSB leadership to participate in the array of leadership, training and service delivery opportunities relevant to forensic consumers.

OIG Recommendation No. 5: That DBHDS work to improve attorney understanding of the graduated release process and develop a process for measuring incidents of individuals receiving inaccurate information about the process, expectations, and challenges.

This recommendation is linked to two findings:

- Finding No. 24: (Currently in facility) Individuals admitted pursuant to an NGRI plea appear to have had a limited understanding of the facility level treatment associated with their plea. Six individuals interviewed indicated that they expected to be treated for less than a year and then released to their community.
- Finding No. 28: (Prior facility resident –now in the community) Individuals admitted pursuant to an NGRI plea appear to have had a limited understanding of the facility level treatment associated with their plea. Four individuals interviewed indicated that they expected to be treated for less than a year and then released to their community.

DBHDS Response to No. 5: *The choice to plead insanity should not be based on treatment considerations, but on the consumer's mental state at the time of the offense, as insanity is not a clinical label but a legal designation based on a very specific set of criteria defined by Virginia case law. DBHDS forensic staff routinely provide consultation and training, upon request, to attorneys representing NGRI acquittees. During the first year following the NGRI plea, acquittees have two opportunities for their commitment to be reviewed by the court, first during temporary custody and again at the end of the first year, and on an annual basis thereafter. An acquittee's expectations regarding release are often impacted by his or her degree of insight into the level of recovery needed to achieve in order for the court to determine it is safe to allow them into the community. It is important to note that courts may release an insanity aquittee into the community regardless of the acquittee's status within the NGRI privileging process. DBDHS will continue to provide consultation and training to attorneys and other members of the judiciary, and will develop a process for assessing an insanity acquittee's understanding and expectations regarding the privileging process.*

There is no timeline for this process. It is an ongoing activity of the growing number of community CIT programs and of specific activities undertaken by forensic staff at DBHDS hospitals and from central office. Progress on these activities will be reported in the next update to this report.

OIG Report No. 206-11: *OIG Review of the Emergency Services: Individuals meeting statutory criteria for temporary detention not admitted to a psychiatric facility for further evaluation and treatment.*

Finding Number 1: CSB/BHA emergency services staff are the behavioral health system's *first responders* and these professionals routinely overcome formidable obstacles to cobble-together creative solutions to assure the safety of Virginians who are incapable of caring for themselves. Thanks in large measure to their dedication and skill, the majority of emergency services for Virginians in crisis are delivered as contemplated by the *Code*.

Nevertheless, during this study, 72 individuals determined to meet the statutory criteria for temporary detention were denied access to inpatient psychiatric treatment. To contextualize the 72 failed TDOs, one needs to appreciate that this number is approximately 1½% of the estimated 5,000 TDOs that were successfully executed statewide during the three-months of the study. In summary, this study confirmed that access to inpatient treatment is generally, but not always, available to people experiencing psychiatric crises.

When a person, determined by specially-trained clinicians to be incapable of caring for themselves and at risk for harming themselves or others, is unable to secure the recommended treatment and hospitalization, this outcome represents a systemic failure to address the needs of that individual and places the person and his/her community at risk. Moreover, a failed TDO may rise to the level of a *sentinel event* as defined by the Joint Commission.[19]

Finding Number 1a: The study confirmed last year's anecdotal reports of *streeting* and documented that 72 persons, meeting statutory criteria for temporary detention were denied admission to public and private behavioral health facilities.[20]

[19] "A sentinel event is an unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof. Serious injury specifically includes loss of limb or function. The phrase "or the risk thereof" includes any process variation for which a recurrence would carry a significant chance of a serious adverse outcome." The Joint Commission, January, 2011: (http://www.jointcommission.org)

[20] Wherever possible in this Report, the OIG has substituted "failed TDO" for "streeted" because of reasonable objections to the negative connotations attached to the terms "streeted" or "streeting." The term "streeted" was used in Hampton Roads to categorize individuals that met criteria for temporary detention who received a less intensive intervention than inpatient treatment – or no intervention and were released. In this study, the majority of these 72 cases received a less intensive intervention than inpatient treatment.

Recommendation Number 1a: That DBHDS identify "UNEXECUTED TDO" as a Quality Indicator of access to clinically appropriate services and develop a mechanism that allows for consistent tracking of such incidents at the Board and regional level.

DBHDS Response*: DBHDS supports this recommendation.*

Finding Number 1b: The study documented that TDOs for at least 273 individuals were executed beyond the six-hour time limit imposed by statute: This is approximately 5½% of the estimated 5,000 TDOs executed during the three-month study. The experience for these citizens was that it required a statewide average of 16.6 hours for the order to be executed and for them to be admitted for the clinically indicated services.

Recommendation Number 1b: That DBHDS identify "TDO EXECUTED BEYOND 6 HOURS" as a Quality Indicator for the timely execution of TDOs, and develop a mechanism that allows for consistent tracking of such incidents at the Board and regional level.

DBHDS Response: *DBHDS supports this recommendation.*

Finding Number 2: Ineffective medical screening and clearance processes for persons restrained for evaluation under ECOs and TDOs have been, and remain, a chronic challenge in the Commonwealth. In 2007, the DBHDS published thoughtful *Guidance Materials* addressing many of the issues identified by ED Medical Directors and CSB ES Directors throughout the state in recent discussions with the Inspector General; however, to date, the recommendations of the *Guidance Materials* have not been consistently adopted statewide.

There is broad consensus that adoption of best practices and the common understanding articulated in the *Guidance Materials* will improve outcomes for persons served, bring down costs system wide, and reduce the number of failed TDOs.

Recommendation Number 2a: That the DBHDS assemble an *ad hoc* group of stakeholders to review and update the *Medical Screening and Assessment Guidance* Material *(March 13, 2007)* as necessary, and reissue these constructive guidelines by October 30, 2012.

DBHDS Response: *DBHDS supports this recommendation.*

Recommendation Number 2b: That the DBHDS include a provision in its next *Performance Contract* with all CSBs requiring specific local or regional monitoring of problems associated with medical screening and clearance for persons meeting criteria for an ECO or a TDO, and report results to the DBHDS at regular intervals.

DBHDS Response: *DBHDS supports this recommendation.*

Recommendation Number 2c: That the DBHDS coordinate an effort among all state-operated facilities to immediately adopt and implement the recommendations and approach of the *Guidance Materials* and develop best practices to drive quality improvement in this vital area.

DBHDS Response*: DBHDS supports this recommendation.*

Recommendation Number 2d: That the DBHDS monitor the implementation of the *Guidance Materials* by CSBs and state-operated facilities and publish its report by April 15, 2013, detailing the progress of this initiative.

DBHDS Response*: DBHDS supports this recommendation.*

Finding Number 3: This study revealed that state-operated behavioral health facilities were not consistently contacted, or utilized, as an available resource for individuals assessed as appropriate for inpatient level of care under a temporary detention order. Facilities were not contacted in approximately half of the 72 cases in which a TDO was warranted, but not executed.[21] Failure, or inability, to utilize the state-operated facilities as a safety net may contribute to extended and unnecessary stays in local emergency rooms and placement of individuals in less appropriate levels of care; potentially placing both the individual and the community at risk.

Recommendation Number 3a: It is recommended that DBHDS and the CSBs develop working protocols for assuring that state-operated facilities, or the regional access (utilization) committees, are contacted in each case in which local placement of persons determined to need inpatient care is not secured. The responsibilities of each entity in facilitating a TDO admission to the DBHDS facility should be detailed in the protocols. The protocols should be consistent with the intent of State Board Policy 1038 (SYS) 06-1: *The Safety Net of Public Services*.

DBHDS Response*: DBHDS supports this recommendation.*

Recommendation Number 3b: It is recommended that DBHDS establish a quality improvement initiative for monitoring TDO admissions to the state-operated behavioral health facilities with periodic reporting to the Commissioner and the OIG.

DBHDS Response*: DBHDS supports this recommendation.*

[21] The survey instrument did not record why state facilities were not contacted – noting only the lack of contact. It may be that some screeners knew from previous conversations that the state facility was at capacity and was not accepting TDO admissions.

Recommendation Number 3c: It is recommended that, from among each region's CSBs, a senior-level person be designated and empowered to locate a private or state-operated facility with an appropriate bed to admit individuals meeting statutory criteria for temporary detention.

DBHDS Response*: DBHDS supports this recommendation.*

Recommendation Number 3d**:** It is recommended that the DBHDS develop a viable system that responds any time that an individual meeting statutory criteria for temporary detention is denied admission to a state-operated facility. The intent of this recommendation is to empower a senior member of the DBHDS to contemporaneously consult, or to intervene where necessary and appropriate, with regional utilization managers to create an alternative to a failed TDO for persons requiring hospitalization or treatment.

DBHDS Response*: DBHDS supports this recommendation.*

Finding Number 4: PPR III and PPR V had a disproportionate number of failed TDOs compared to other regions of the state – accounting for 75% of the total failed TDOs during the study period.

Recommendation Number 4: That this study be repeated in FY 2013 in PPR III and PPR V to determine what progress has been made to eliminate failed TDOs from these two regions.

DBHDS Response*: DBHDS supports this recommendation and will collaborate with the Office of the Inspector General on study implementation.*

Finding Number 5: That private psychiatric hospitals regularly lack an *appropriate bed* to serve some of the most challenging individuals. The regional state facilities in PPR III (SWVMHI) and PPR V (ESH) are regularly at full operating capacity and unable to admit persons meeting criteria for temporary detention. The lack of private or public beds to receive TDOs contributes to the number of failed TDOs in these two regions of the state.

Recommendation Number 5: That immediate consideration be given by the Regional Access Committees in PPR III and PPR V to developing performance contracts with one or more private facilities in PPR V and PPR III to create a category of "intensive beds" in a milieu and environmental setting that can serve some of the most challenging individuals admitted under a TDO – without jeopardizing the safety of other patients, staff, or the person.

DBHDS Response*: DBHDS supports increased access to inpatient or other clinically appropriate treatment settings in the community for persons needing this level of care and will work with CSBs and regions to help identify needs, develop options, and identify needed resources.*

Finding Number 6: In Southwest Virginia and Hampton Roads, the state-operated facilities are, at times, unable to provide safety net admissions for individuals that are incapable of caring for themselves because Eastern State Hospital (ESH) and Southwest Virginia Mental Health Institute (SWVMHI) are regularly at, or beyond, their operating capacities.

In the judgment of the OIG, if the Commonwealth is to eliminate failed TDOs, and the attendant risk to the person, their family, and the community, and to provide a reliable safety net for its citizens, it must create additional community capacity to serve discharge-ready individuals currently residing at ESH and SWVMHI.

Recommendation Number 6: That the DBHDS evaluate the relevant issues at SWVMHI, ESH, and each region's unique problems and identify the additional programs and resources necessary to create the community capacity needed to allow these state-operated facilities the census flexibility to become reliable safety nets for individuals determined to need temporary detention and treatment.

DBHDS Response*: DBHDS supports this recommendation.*

Finding Number 7: Anecdotal reports suggest that, in some locales, this study has raised the consciousness of some CSBs that consumers were not receiving the services deemed necessary to assure their safety and the safety of others. To their credit, these CSBs report sharpening their focus on failed TDOs, and they have commenced closely monitoring the treatment and outcomes for these individuals.

No recommendation associated with this Finding

APPENDIX A

United States of America v. the Commonwealth of Virginia, *Settlement Agreement* U.S. District Court, Eastern District of Virginia (January 26, 2012)

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF VIRGINIA
Richmond Division

UNITED STATES OF AMERICA,	)	
	)	
Plaintiff,	)	
	)	CIVIL ACTION NO:
v.	)	
	)	
COMMONWEALTH OF VIRGINIA,	)	
	)	
Defendant.	)	
	)	
_____	)	

SETTLEMENT AGREEMENT

I. Introduction

A. The Commonwealth of Virginia ("the Commonwealth") and the United States (together, "the Parties") are committed to full compliance with Title II of the Americans with Disabilities Act ("ADA"), 42 U.S.C. § 12101, as interpreted by *Olmstead v. L.C.*, 527 U.S. 581 (1999). This Agreement is intended to ensure the Commonwealth's compliance with the ADA and *Olmstead*, which require that, to the extent the Commonwealth offers services to individuals with intellectual and developmental disabilities, such services shall be provided in the most integrated setting appropriate to meet their needs. Accordingly, throughout this document, the Parties intend that the goals of community integration, self-determination, and quality services will be achieved.

B. On August 21, 2008, the United States Department of Justice ("United States") initiated an investigation of Central Virginia Training Center ("CVTC"), the largest of Virginia's five state-operated intermediate care facilities for persons with intellectual and developmental disabilities ("ICFs"), pursuant to the Civil Rights of Institutionalized Persons Act ("CRIPA"), 42 U.S.C. § 1997. On April 21, 2010, the United States notified the Commonwealth that it was expanding its investigation under the ADA to focus on the Commonwealth's compliance with the ADA's integration mandate and *Olmstead* with respect to individuals at CVTC. During the course of the expanded investigation, however, it became clear that an examination of the Commonwealth's measures to address the rights of individuals at CVTC under the ADA and *Olmstead* implicated the statewide system for serving individuals with intellectual and developmental disabilities and required a broader scope of review. Accordingly, the policies and practices that the United States examined in its expanded investigation were statewide in scope and application. On February 10, 2011, the United States issued its findings, concluding that the Commonwealth fails to provide services to individuals with intellectual and

developmental disabilities in the most integrated setting appropriate to their needs as required by the ADA and *Olmstead*.

C. The Commonwealth engaged with the United States in open dialogue about the allegations and worked with the United States to resolve the alleged violations of the ADA arising out of the Commonwealth's provision of services for individuals with intellectual and developmental disabilities.

D. In order to resolve all issues pending between the Parties without the expense, risks, delays, and uncertainties of litigation, the United States and the Commonwealth agree to the terms of this Settlement Agreement as stated below. This Agreement resolves the United States' investigation of CVTC, as well as its broader examination of the Commonwealth's compliance with the ADA and *Olmstead* with respect to individuals with intellectual and developmental disabilities.

E. By entering into this Settlement Agreement, the Commonwealth does not admit to the truth or validity of any claim made against it by the United States.

F. The Parties acknowledge that the Court has jurisdiction over this case and authority to enter this Settlement Agreement and to enforce its terms as set forth herein.

G. No person or entity is intended to be a third-party beneficiary of the provisions of this Settlement Agreement for purposes of any other civil, criminal, or administrative action, and, accordingly, no person or entity may assert any claim or right as a beneficiary or protected class under this Settlement Agreement in any separate action. This Settlement Agreement is not intended to impair or expand the right of any person or organization to seek relief against the Commonwealth or their officials, employees, or agents.

H. The Court has jurisdiction over this action pursuant to 28 U.S.C. § 1331; 28 U.S.C. § 1345; and 42 U.S.C. §§ 12131-12132. Venue is proper in this district pursuant to 28 U.S.C. § 1391(b).

II. Definitions

A. "Developmental disability" means a severe, chronic disability of an individual that: (1) is attributable to a mental or physical impairment or combination of mental and physical impairments; (2) is manifested before the individual attains age 22; (3) is likely to continue indefinitely; (4) results in substantial functional limitations in 3 or more of the following areas of major life activity: (a) self-care; (b) receptive and expressive language; (c) learning; (d) mobility; (e) self-direction; (f) capacity for independent living; (g) economic self-sufficiency; and (5) reflects the individual's need for a combination and sequence of special, interdisciplinary, or generic services, individualized supports, or other forms of assistance that are of lifelong or extended duration and are individually planned and coordinated. 42 U.S.C. § 15002.

B. "Intellectual disability" means a disability characterized by significant limitations both in intellectual functioning (reasoning, learning, problem solving) and in adaptive behavior, which covers a range of everyday social and practical skills. This disability originates before the age of 18. An intellectual disability is a type of developmental disability.

C. Home and Community-Based Services Waivers ("HCBS Waivers") means the program approved by the Centers for Medicare and Medicaid Services ("CMS") for the purpose of providing services in community settings for eligible persons with developmental disabilities who would otherwise be served in ICFs. For purposes of this Settlement Agreement, "HCBS Waivers" includes the Intellectual Disabilities Waiver ("ID Waiver") and the Individual and Family Developmental Disabilities Support Waiver ("DD Waiver"), or any other CMS approved waivers that are equivalent to the ID or DD Waivers that may be created after the execution of this Agreement.

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

III. Serving Individuals with Developmental Disabilities In the Most Integrated Setting

A. To prevent the unnecessary institutionalization of individuals with ID/DD and to provide them opportunities to live in the most integrated settings appropriate to their needs consistent with their informed choice, the Commonwealth shall develop and provide the community services described in this Section.

B. Target Population:

1. The target population of this Agreement shall include individuals with ID/DD who meet any of the following additional criteria:

   a. are currently residing at any of the Training Centers;

   b. who (i) meet the criteria for the wait list for the ID waiver, or (ii) meet the criteria for the wait list for the DD waiver; or

   c. currently reside in a nursing home or ICF.

2. The Commonwealth shall not exclude any otherwise qualifying individual from the target population due to the existence of complex behavioral or medical needs or of co-occurring conditions, including but not limited to, mental illness, traumatic brain injuries, or other neurological conditions.

3. Individuals shall remain in the target population if they receive HCBS waiver services or individual and family supports under this Agreement.

4. Individuals who are otherwise in the target population and who have been released from forensic status or placed on conditional release by a court shall not be excluded

from the target population solely on the basis of their former forensic status or current conditional release status.

5. Inclusion in the target population does not guarantee or create a right to receipt of services.

C. Enhancement of Community Services

1. By June 30, 2021, the Commonwealth shall create 4,170 waiver slots for the target population, to be broken down as follows:

a. The Commonwealth shall create a minimum of 805 waiver slots to enable individuals in the target population in the Training Centers to transition to the community according to the following schedule:

i. In State Fiscal Year 2012, 60 waiver slots

ii. In State Fiscal Year 2013, 160 waiver slots

iii. In State Fiscal Year 2014, 160 waiver slots

iv. In State Fiscal Year 2015, 90 waiver slots

v. In State Fiscal Year 2016, 85 waiver slots

vi. In State Fiscal Year 2017, 90 waiver slots

vii. In State Fiscal Year 2018, 90 waiver slots

viii. In State Fiscal Year 2019, 35 waiver slots

ix. In State Fiscal Year 2020, 35 waiver slots

b. The Commonwealth shall create a minimum of 2,915 waiver slots to prevent the institutionalization of individuals with intellectual disabilities in the target population who are on the urgent waitlist for a waiver, or to transition to the community individuals with intellectual disabilities under 22 years of age from institutions other than the Training Centers (i.e., ICFs and nursing facilities), according to the following schedule:

i. In State Fiscal Year 2012, 275 waiver slots

ii. In State Fiscal Year 2013, 225 waiver slots, including 25 slots prioritized for individuals under 22 years of age residing in nursing homes and the largest ICFs

iii. In State Fiscal Year 2014, 225 waiver slots, including 25 slots prioritized for individuals under 22 years of age residing in nursing homes and the largest ICFs

iv. In State Fiscal Year 2015, 250 waiver slots, including 25 slots prioritized for individuals under 22 years of age residing in nursing homes and the largest ICFs

v. In State Fiscal Year 2016, 275 waiver slots, including 25 slots prioritized for individuals under 22 years of age residing in nursing homes and the largest ICFs

vi. In State Fiscal Year 2017, 300 waiver slots

vii. In State Fiscal Year 2018, 325 waiver slots

viii. In State Fiscal Year 2019, 325 waiver slots

ix. In State Fiscal Year 2020, 355 waiver slots

x. In State Fiscal Year 2021, 360 waiver slots

c. The Commonwealth shall create a minimum of 450 waiver slots to prevent the institutionalization of individuals with developmental disabilities other than intellectual disabilities in the target population who are on the waitlist for a waiver, or to transition to the community individuals with developmental disabilities other than intellectual disabilities under 22 years of age from institutions other than the Training Centers (i.e., ICFs and nursing facilities), according to the following schedule:

i. In State Fiscal Year 2012, 150 waiver slots

ii. In State Fiscal Year 2013, 25 waiver slots, including 15 prioritized for individuals under 22 years of age residing in nursing homes and the largest ICFs

iii. In State Fiscal Year 2014, 25 waiver slots, including 15 prioritized for individuals under 22 years of age residing in nursing homes and the largest ICFs

iv. In State Fiscal Year 2015, 25 waiver slots, including 15 prioritized for individuals under 22 years of age residing in nursing homes and the largest ICFs

v. In State Fiscal Year 2016, 25 waiver slots, including 15 prioritized for individuals under 22 years of age residing in nursing homes and the largest ICFs

vi. In State Fiscal Year 2017, 25 waiver slots, including 10 prioritized for individuals under 22 years of age residing in nursing homes and the largest ICFs

vii. In State Fiscal Year 2018, 25 waiver slots, including 10 prioritized for individuals under 22 years of age residing in nursing homes and the largest ICFs

viii. In State Fiscal Year 2019, 25 waiver slots

ix. In State Fiscal Year 2020, 50 waiver slots

x. In State Fiscal Year 2021, 75 waiver slots

d. If the Commonwealth creates more waiver slots than are required in Sections III.C.1.a, b, or c above for a particular fiscal year, the number of slots created above the requirement shall be counted towards the slots required to be created in the subsequent fiscal year in the relevant Section.

2. The Commonwealth shall create an individual and family support program for individuals with ID/DD whom the Commonwealth determines to be most at risk of institutionalization, according to the following schedule:

a. In State Fiscal Year 2013, a minimum of 700 individuals supported

b. In State Fiscal Year 2014, a minimum of 1000 individuals supported

c. In State Fiscal Year 2015, a minimum of 1000 individuals supported

d. In State Fiscal Year 2016, a minimum of 1000 individuals supported

e. In State Fiscal Year 2017, a minimum of 1000 individuals supported

f. In State Fiscal Year 2018, a minimum of 1000 individuals supported

g. In State Fiscal Year 2019, a minimum of 1000 individuals supported

h. In State Fiscal Year 2020, a minimum of 1000 individuals supported

i. In State Fiscal Year 2021, a minimum of 1000 individuals supported

3. If the Commonwealth substantially changes or amends its ID or DD waivers, the Parties shall meet within 15 days of final approval from CMS to determine if any provisions of this Agreement should be amended. The Parties agree that under any new terms, at least as many individuals in each category in Sections III.C.1.a, b, and c and C.2 above shall receive HCBS waivers and individual and family supports under the Agreement. If the Parties cannot reach agreement within 90 days, the Court shall resolve the dispute.

4. With the consent of the United States and the Independent Reviewer, the Commonwealth may re-allocate any unused waiver slot from one category of III.C.1.a-c to another in any State Fiscal Year covered by this Agreement.

5. Case Management

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

b. For the purposes of this agreement, case management shall mean:

i. Assembling professionals and nonprofessionals who provide individualized supports, as well as the individual being served and other persons important to the individual being served, who, through their combined expertise and involvement, develop Individual Support Plans ("ISP") that are individualized, person-centered, and meet the individual's needs;

ii. Assisting the individual to gain access to needed medical, social, education, transportation, housing, nutritional, therapeutic, behavioral, psychiatric, nursing, personal care, respite, and other services identified in the ISP; and

iii. Monitoring the ISP to make timely additional referrals, service changes, and amendments to the plans as needed.

c. Case management shall be provided to all individuals receiving HCBS waiver services under this Agreement by case managers who are not directly providing such services to the individual or supervising the provision of such services. The Commonwealth shall include a provision in the Community Services Board ("CSB") Performance Contract that requires CSB case managers to give individuals a choice of service providers from which the individual may receive approved waiver services and to present practicable options of service providers based on the preferences of the individual, including both CSB and non-CSB providers.

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

6. Crisis Services

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

i. Provide timely and accessible support to individuals with intellectual and developmental disabilities who are experiencing crises, including crises due to behavioral or psychiatric issues, and to their families;

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

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

b. The crisis system shall include the following components:

i. Crisis Point of Entry

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

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

ii. Mobile crisis teams

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

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

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

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

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

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

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

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

iii. Crisis stabilization programs

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

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

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

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

E. With the exception of the Pathways Program operated at Southwestern Virginia Training Center ("SWVTC"), crisis stabilization programs shall not be located on the grounds of the Training Centers or hospitals with inpatient psychiatric beds. By July 1, 2015, the Pathways Program at SWVTC will cease providing crisis stabilization services and shall be replaced by off-site crisis stabilization programs with sufficient capacity to meet the needs of the target population in that Region.

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

G. By June 30, 2013, the Commonwealth shall develop an additional crisis stabilization program in each Region as determined necessary by the Commonwealth to meet the needs of the target population in that Region.

7. Integrated Day Activities and Supported Employment

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

b. The Commonwealth shall maintain its membership in the State Employment Leadership Network ("SELN") established by the National Association of State Developmental Disability Directors. The Commonwealth shall establish a state policy on Employment First for the target population and include a term in the CSB Performance Contract requiring application of this policy. The Employment

First policy shall, at a minimum, be based on the following principles: (1) individual supported employment in integrated work settings is the first and priority service option for individuals with intellectual or developmental disabilities receiving day program or employment services from or funded by the Commonwealth; (2) the goal of employment services is to support individuals in integrated work settings where they are paid minimum or competitive wages; and (3) employment services and goals must be developed and discussed at least annually through a person-centered planning process and included in ISPs. The Commonwealth shall have at least one employment service coordinator to monitor implementation of Employment First practices for individuals in the target population.

i. Within 180 days of this Agreement, the Commonwealth shall develop, as part of its Employment First policy, an implementation plan to increase integrated day opportunities for individuals in the target population, including supported employment, community volunteer activities, community recreational opportunities, and other integrated day activities. The plan will be under the direct supervision of a dedicated employment service coordinator for the Commonwealth and shall:

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

   B. Establish, for individuals receiving services through the HCBS waivers:

      1. Annual baseline information regarding:

         a. The number of individuals who are receiving supported employment;

         b. The length of time people maintain employment in integrated work settings;

         c. Amount of earnings from supported employment;

         d. The number of individuals in pre-vocational services as defined in 12 VAC 30-120-211 in effect on the effective date of this Agreement; and

         e. The length of time individuals remain in pre-vocational services.

      2. Targets to meaningfully increase:

         a. The number of individuals who enroll in supported employment each year; and

         b. The number of individuals who remain employed in integrated work settings at least 12 months after the start of supported employment.

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

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

8. Access and Availability of Services

a. The Commonwealth shall provide transportation to individuals receiving HCBS waiver services in the target population in accordance with the Commonwealth's HCBS Waivers.

b. The Commonwealth shall publish guidelines for families seeking intellectual and developmental disability services on how and where to apply for and obtain services. The guidelines will be updated annually and will be provided to appropriate agencies for use in directing individuals in the target population to the correct point of entry to access services.

9. The Commonwealth has made public its long-standing goal and policy, independent of and adopted prior to this Agreement or the Department of Justice's findings, of transitioning from an institutional model of care to a community-based system that meets the needs of all individuals with ID/DD, including those with the most complex needs, and of using its limited resources to serve effectively the greatest number of individuals with ID/DD. This goal and policy have resulted in a decline in the population of the state training centers from approximately 6000 individuals to approximately 1000 individuals. The Commonwealth has determined that this significant and ongoing decline makes continued operation of residential services fiscally impractical. Consequently, and in accordance with the Commonwealth's policy of transitioning its system of developmental services to a community-based system, the Commonwealth will provide to the General Assembly within one year of the effective date of this Agreement, a plan, developed in consultation with the Chairmen of Virginia's House of Delegates Appropriations and Senate Finance Committees, to cease residential operations at four of the five training centers by the end of State Fiscal Year 2021.

D. Community Living Options

1. The Commonwealth shall serve individuals in the target population in the most integrated setting consistent with their informed choice and needs.

2. The Commonwealth shall facilitate individuals receiving HCBS waivers under this Agreement to live in their own home, leased apartment, or family's home, when such a placement is their informed choice and the most integrated setting appropriate to their needs. To facilitate individuals living independently in their own home or

apartment, the Commonwealth shall provide information about and make appropriate referrals for individuals to apply for rental or housing assistance and bridge funding through all existing sources, including local, State, or federal affordable housing or rental assistance programs (tenant-based or project-based) and the fund described in Section III.D.4 below.

3. Within 365 days of this Agreement, the Commonwealth shall develop a plan to increase access to independent living options such as individuals' own homes or apartments. The Commonwealth undertakes this initiative recognizing that comparatively modest housing supports often can enable individuals to live successfully in the most integrated settings appropriate to their needs.

    a. The plan will be developed under the direct supervision of a dedicated housing service coordinator for the Department of Behavioral Health and Developmental Services ("DBHDS") and in coordination with representatives from the Department of Medical Assistance Services ("DMAS"), Virginia Board for People with Disabilities, Virginia Housing Development Authority, Virginia Department of Housing and Community Development, and other organizations as determined appropriate by DBHDS.

    b. The plan will establish, for individuals receiving or eligible to receive services through the HCBS waivers under this Agreement:

        i. Baseline information regarding the number of individuals who would choose the independent living options described above, if available; and

        ii. Recommendations to provide access to these settings during each year of this Agreement.

4. Within 365 days of this Agreement, the Commonwealth shall establish and begin distributing, from a one-time fund of $800,000 to provide and administer rental assistance in accordance with the recommendations described above in Section III.D.3.b.ii, to as many individuals as possible who receive HCBS waivers under this Agreement, express a desire for living in their own home or apartment, and for whom such a placement is the most integrated setting appropriate to their needs.

5. Individuals in the target population shall not be served in a sponsored home or any congregate setting, unless such placement is consistent with the individual's choice after receiving options for community placements, services, and supports consistent with the terms of Section IV.B.9 below.

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

7. The Commonwealth shall include a term in the annual performance contract with the CSBs to require case managers to continue to offer education about less restrictive

community options on at least an annual basis to any individuals living outside their own home or family's home (and, if relevant, to their authorized representative or guardian).

E. Community Resource Consultants and Regional Support Teams

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

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

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

    a. The PST is having difficulty identifying or locating a particular community placement, services and supports for an individual within 3 months of the individual's receipt of HCBS waiver services.

    b. The PST recommends and, upon his/her review, the CRC also recommends that an individual residing in his or her own home, his or her family's home, or a sponsored residence be placed in a congregate setting with five or more individuals.

    c. The PST recommends and, upon his/her review, the CRC also recommends an individual residing in any setting be placed in a nursing home or ICF.

    d. There is a pattern of an individual repeatedly being removed from his or her current placement.

IV. Discharge Planning and Transition from Training Center

By July 2012, the Commonwealth will have implemented Discharge and Transition Planning processes at all Training Centers consistent with the terms of this Section, excluding other dates agreed upon, and listed separately in this Section.

A. To ensure that individuals are served in the most integrated setting appropriate to their needs, the Commonwealth shall develop and implement discharge planning and transition processes at all Training Centers consistent with the terms of this Section and person-centered principles.

B. Discharge Planning and Discharge Plans

1. Discharge planning shall begin upon admission.

2. Discharge planning shall drive treatment of individuals in any Training Center and shall adhere to the principles of person-centered planning.

3. Individuals in Training Centers shall participate in their treatment and discharge planning to the maximum extent practicable, regardless of whether they have authorized representatives. Individuals shall be provided the necessary support (including, but not limited to, communication supports) to ensure that they have a meaningful role in the process.

4. The goal of treatment and discharge planning shall be to assist the individual in achieving outcomes that promote the individual's growth, well being, and independence, based on the individual's strengths, needs, goals, and preferences, in the most integrated settings in all domains of the individual's life (including community living, activities, employment, education, recreation, healthcare, and relationships).

5. The Commonwealth shall ensure that discharge plans are developed for all individuals in its Training Centers through a documented person-centered planning and implementation process and consistent with the terms of this Section. The discharge plan shall be an individualized support plan for transition into the most integrated setting consistent with informed individual choice and needs and shall be implemented accordingly. The final discharge plan (developed within 30 days prior to discharge) will include:

a. Provision of reliable information to the individual and, where applicable, the authorized representative, regarding community options in accordance with Section IV.B.9;

b. Identification of the individual's strengths, preferences, needs (clinical and support), and desired outcomes;

c. Assessment of the specific supports and services that build on the individual's strengths and preferences to meet the individual's needs and achieve desired outcomes, regardless of whether those services and supports are currently available;

d. Listing of specific providers that can provide the identified supports and services that build on the individual's strengths and preferences to meet the individual's needs and achieve desired outcomes;

e. Documentation of barriers preventing the individual from transitioning to a more integrated setting and a plan for addressing those barriers.

i. Such barriers shall not include the individual's disability or the severity of the disability.

ii. For individuals with a history of re-admission or crises, the factors that led to re-admission or crises shall be identified and addressed.

6. Discharge planning will be done by the individual's PST. The PST includes the individual receiving services, the authorized representative (if any), CSB case manager, Training Center staff, and persons whom the individual has freely chosen or requested to participate (including but not limited to family members and close friends). Through a person-centered planning process, the PST will assess an individual's treatment, training, and habilitation needs and make recommendations for services, including recommendations of how the individual can be best served.

7. Discharge planning shall be based on the presumption that, with sufficient supports and services, all individuals (including individuals with complex behavioral and/or medical needs) can live in an integrated setting.

8. For individuals admitted to a Training Center after the date this Agreement is signed by both parties, the Commonwealth shall ensure that a discharge plan is developed as described herein within 30 days of admission. For all individuals residing in a Training Center on the date that this Agreement is signed by both parties, the Commonwealth shall ensure that a discharge plan is developed as described herein within six months of the effective date of this Agreement.

9. In developing discharge plans, PSTs, in collaboration with the CSB case manager, shall provide to individuals and, where applicable, their authorized representatives, specific options for types of community placements, services, and supports based on the discharge plan as described above, and the opportunity to discuss and meaningfully consider those options.

a. The individual shall be offered a choice of providers consistent with the individual's identified needs and preferences.

b. PSTs and the CSB case manager shall coordinate with the specific type of community providers identified in the discharge plan as providing appropriate community-based services for the individual, to provide individuals, their families, and, where applicable, their authorized representative with opportunities to speak with those providers, visit community placements (including, where feasible, for overnight visits) and programs, and facilitate conversations and meetings with individuals currently living in the community and their families, before being asked to make a choice regarding options. The Commonwealth shall develop family-to-family and peer programs to facilitate these opportunities.

c. PSTs and the CSB case managers shall assist the individual and, where applicable, their authorized representative in choosing a provider after providing the opportunities described above and ensure that providers are timely identified and engaged in preparing for the individual's transition.

10. The Commonwealth shall ensure that Training Center PSTs have sufficient knowledge about community services and supports to: propose appropriate options about how an individual's needs could be met in a more integrated setting; present individuals and their families with specific options for community placements, services, and supports; and, together with providers, answer individuals' and families' questions about community living.

    a. In collaboration with the CSBs and community providers, the Commonwealth shall develop and provide training and information for Training Center staff about the provisions of this Agreement, staff obligations under the Agreement, current community living options, the principles of person-centered planning, and any related departmental instructions. The training will be provided to all applicable disciplines and all PSTs.

    b. Person-centered thinking training will occur during initial orientation and through annual refresher courses. Competency will be determined through documented observation of PST meetings and through the use of person-centered thinking coaches and mentors. Each Training Center will have designated coaches who receive additional training. The coaches will provide guidance to PSTs to ensure implementation of the person-centered tools and skills. Coaches throughout the state will have regular and structured sessions with person-centered thinking mentors. These sessions will be designed to foster additional skill development and ensure implementation of person-centered thinking practices throughout all levels of the Training Centers.

11. In the event that an individual or, where applicable, authorized representative opposes the PST's proposed options for placement in a more integrated setting after being provided the information and opportunities described in Section IV.B.9, the Commonwealth shall ensure that PSTs:

    a. Identify and seek to resolve the concerns of individuals and/or their authorized representatives with regard to community placement;

    b. Develop and implement individualized strategies to address concerns and objections to community placement; and

    c. Document the steps taken to resolve the concerns of individuals and/or their authorized representatives and provide information about community placement.

12. All individuals in the Training Center shall be provided opportunities for engaging in community activities to the fullest extent practicable, consistent with their identified needs and preferences, even if the individual does not yet have a discharge plan for transitioning to the community.

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

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

C. Transition to Community Setting

1. Once a specific provider is selected by an individual, the Commonwealth shall invite and encourage the provider to actively participate in the transition of the individual from the Training Center to the community placement.

2. Once trial visits are completed, the individual has selected a provider, and the provider agrees to serve the individual, discharge will occur within 6 weeks, absent conditions beyond the Commonwealth's control. If discharge does not occur within 6 weeks, the reasons it did not occur will be documented and a new time frame for

discharge will be developed by the PST. Where discharge does not occur within 3 months of selecting a provider, the PST shall identify the barriers to discharge and notify the Facility Director and Community Integration Manager in accordance with Section IV.D.2 below, and the case shall be referred to the Regional Support Teams in accordance with Section IV.D.3 below.

3. The Commonwealth shall develop and implement a system to follow up with individuals after discharge from the Training Centers to identify gaps in care and address proactively any such gaps to reduce the risk of re-admission, crises, or other negative outcomes. The Post Move Monitor, in coordination with the CSB, will conduct post-move monitoring visits within each of three (3) intervals (30, 60, and 90 days) following an individual's movement to the community setting. Documentation of the monitoring visit will be made using the Post Move Monitoring Checklist. The Commonwealth shall ensure those conducting Post Move Monitoring are adequately trained and a reasonable sample of look-behind Post Move Monitoring is completed to validate the reliability of the Post Move Monitoring process.

4. The Commonwealth shall ensure that each individual transitioning from a Training Center shall have a current discharge plan, updated within 30 days prior to the individual's discharge.

5. The Commonwealth shall ensure that the PST will identify all needed supports, protections, and services to ensure successful transition in the new living environment, including what is most important to the individual as it relates to community placement. The Commonwealth, in consultation with the PST, will determine the essential supports needed for successful and optimal community placement. The Commonwealth shall ensure that essential supports are in place at the individual's community placement prior to the individual's discharge from the Training Center. This determination will be documented. The absence of those services and supports identified as non-essential by the Commonwealth, in consultation with the PST, shall not be a barrier to transition.

6. No individual shall be transferred from a Training Center to a nursing home or congregate setting with five or more individuals unless placement in such a facility is in accordance with the individual's informed choice after receiving options for community placements, services, and supports and is reviewed by the Community Integration Manager to ensure such placement is consistent with the individual's informed choice.

7. The Commonwealth shall develop and implement quality assurance processes to ensure that discharge plans are developed and implemented, in a documented manner, consistent with the terms of this Agreement. These quality assurance processes shall be sufficient to show whether the objectives of this Agreement are being achieved. Whenever problems are identified, the Commonwealth shall develop and implement plans to remedy the problems.

D. Community Integration Managers and Regional Support Teams

1. The Commonwealth will create Community Integration Manager ("CIM") positions at each operating Training Center. The CIMs will be DBHDS Central Office staff members who will be physically located at each of the operating Training Centers. The CIMs will facilitate communication and planning with individuals residing in the Training Centers, their families, the PST, and private providers about all aspects of an individual's transition, and will address identified barriers to discharge. The CIMs will have professional experience working in the field of developmental disabilities, and an understanding of best practices for providing community services to individuals with developmental disabilities. The CIMs will have expertise in the areas of working with clinical and programmatic staff, facilitating large, diverse groups of professionals, and providing service coordination across organizational boundaries. The CIMs will serve as the primary connection between the Training Center and DBHDS Central Office. The CIMs will provide oversight, guidance, and technical assistance to the PSTs by identifying strategies for addressing or overcoming barriers to discharge, ensuring that PSTs follow the process described in Sections IV.B and C above, and identifying and developing corrective actions, including the need for any additional training or involvement of supervisory staff.

2. CIMs shall be engaged in addressing barriers to discharge, including in all of the following circumstances:

    a. The PST recommends that an individual be transferred from a Training Center to a nursing home or congregate setting with five or more individuals;

    b. The PST is having difficulty identifying or locating a particular type of community placement, services and supports for an individual within 90 days of development of a discharge plan during the first year of the Agreement; within 60 days of development of a discharge plan during the second year of the Agreement; within 45 days of development of a discharge plan in the third year of the Agreement; and within 30 days of development of a discharge plan thereafter.

    c. The PST cannot agree on a discharge plan outcome within 15 days of the annual PST meeting, or within 30 days after the admission to the Training Center.

    d. The individual or his or her authorized representative opposes discharge after all the requirements described in Section IV.B.9 have been satisfied or refuses to participate in the discharge planning process;

    e. The individual is not discharged within three months of selecting a provider, as described in Section IV.C.2 above. The PST shall identify the barriers to discharge and notify both the facility director and the CIM; or

f. The PST recommends that an individual remain in a Training Center. If the individual remains at the Training Center, an assessment by the PST and the CIM will be performed at 90-day intervals from the decision for the individual to remain at the Training Center, to ensure that the individual is in the most integrated setting appropriate to his or her needs.

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

   a. The CIM is unable, within 2 weeks of the PST's referral to the CIM, to document attainable steps that will be taken to resolve any barriers to community placement enumerated in Section IV.D.2 above.

   b. A PST continues to recommend placement in a Training Center at the second quarterly review following the PST's recommendation that an individual remain in a Training Center (Section IV.D.2.f), and at all subsequent quarterly reviews that maintain the same recommendation. This paragraph shall not take effect until two years after the effective date of this Agreement.

   c. The CIM believes external review is needed to identify additional steps that can be taken to remove barriers to discharge.

4. The CIM shall provide monthly reports to DBHDS Central Office regarding the types of placements to which individuals have been placed, including recommendations that individuals remain at a Training Center.

V. Quality and Risk Management System

A. To ensure that all services for individuals receiving services under this Agreement are of good quality, meet individuals' needs, and help individuals achieve positive outcomes, including avoidance of harms, stable community living, and increased integration, independence, and self-determination in all life domains (e.g., community living, employment, education, recreation, healthcare, and relationships), and to ensure that appropriate services are available and accessible for individuals in the target population, the Commonwealth shall develop and implement a quality and risk management system that is consistent with the terms of this Section.

B. The Commonwealth's Quality Management System shall: identify and address risks of harm; ensure the sufficiency, accessibility, and quality of services to meet individuals' needs in integrated settings; and collect and evaluate data to identify and respond to trends to ensure continuous quality improvement.

C. Risk Management

1. The Commonwealth shall require that all Training Centers, CSBs, and other community providers of residential and day services implement risk management processes, including establishment of uniform risk triggers and thresholds, that enable them to adequately address harms and risks of harm. Harm includes any physical injury, whether caused by abuse, neglect, or accidental causes.

2. The Commonwealth shall have and implement a real time, web-based incident reporting system and reporting protocol. The protocol shall require that any staff of a Training Center, CSB, or community provider aware of any suspected or alleged incident of abuse or neglect as defined by Virginia Code § 37.2-100 in effect on the effective date of this Agreement, serious injury as defined by 12 VAC 35-115-30 in effect on the effective date of this Agreement, or deaths directly report such information to the DBHDS Assistant Commissioner for Quality Improvement or his or her designee.

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

4. The Commonwealth shall offer guidance and training to providers on proactively identifying and addressing risks of harm, conducting root cause analysis, and developing and monitoring corrective actions.

5. The Commonwealth shall conduct monthly mortality reviews for unexplained or unexpected deaths reported through its incident reporting system. The Commissioner shall establish the monthly mortality review team, to include the DBHDS Medical Director, the Assistant Commissioner for Quality Improvement, and others as determined by the Department who possess appropriate experience, knowledge, and skills. The team shall have at least one member with the clinical experience to conduct mortality reviews who is otherwise independent of the State. Within ninety days of a death, the monthly mortality review team shall: (a) review, or document the unavailability of: (i) medical records, including physician case notes and nurses notes, and all incident reports, for the three months preceding the individual's death;

(ii) the most recent individualized program plan and physical examination records; (iii) the death certificate and autopsy report; and (iv) any evidence of maltreatment related to the death; (b) interview, as warranted, any persons having information regarding the individual's care; and (c) prepare and deliver to the DBHDS Commissioner a report of deliberations, findings, and recommendations, if any. The team also shall collect and analyze mortality data to identify trends, patterns, and problems at the individual service-delivery and systemic levels and develop and implement quality improvement initiatives to reduce mortality rates to the fullest extent practicable.

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

D. Data to Assess and Improve Quality

1. The Commonwealth's HCBS waivers shall operate in accordance with the Commonwealth's CMS-approved waiver quality improvement plan to ensure the needs of individuals enrolled in a waiver are met, that individuals have choice in all aspects of their selection of goals and supports, and that there are effective processes in place to monitor participant health and safety. The plan shall include evaluation of level of care; development and monitoring of individual service plans; assurance of qualified providers; identification, response and prevention of occurrences of abuse, neglect and exploitation; administrative oversight of all waiver functions including contracting; and financial accountability. Review of data shall occur at the local and state levels by the CSBs and DBHDS/DMAS, respectively.

2. The Commonwealth shall collect and analyze consistent, reliable data to improve the availability and accessibility of services for individuals in the target population and the quality of services offered to individuals receiving services under this Agreement. The Commonwealth shall use data to:

   a. identify trends, patterns, strengths, and problems at the individual, service-delivery, and systemic levels, including, but not limited to, quality of services, service gaps, accessibility of services, serving individuals with complex needs, and the discharge and transition planning process;

   b. develop preventative, corrective, and improvement measures to address identified problems;

   c. track the efficacy of preventative, corrective, and improvement measures; and

   d. enhance outreach, education, and training.

3. The Commonwealth shall begin collecting and analyzing reliable data about individuals receiving services under this Agreement selected from the following areas

in State Fiscal Year 2012 and will ensure reliable data is collected and analyzed from each of these areas by June 30, 2014. Multiple types of sources (e.g., providers, case managers, licensing, risk management, Quality Service Reviews) can provide data in each area, though any individual type of source need not provide data in every area:

a. Safety and freedom from harm (e.g., neglect and abuse, injuries, use of seclusion or restraints, deaths, effectiveness of corrective actions, licensing violations);

b. Physical, mental, and behavioral health and well being (e.g., access to medical care (including preventative care), timeliness and adequacy of interventions (particularly in response to changes in status));

c. Avoiding crises (e.g., use of crisis services, admissions to emergency rooms or hospitals, admissions to Training Centers or other congregate settings, contact with criminal justice system);

d. Stability (e.g., maintenance of chosen living arrangement, change in providers, work/other day program stability);

e. Choice and self-determination (e.g., service plans developed through person-centered planning process, choice of services and providers, individualized goals, self-direction of services);

f. Community inclusion (e.g., community activities, integrated work opportunities, integrated living options, educational opportunities, relationships with non-paid individuals);

g. Access to services (e.g., waitlists, outreach efforts, identified barriers, service gaps and delays, adaptive equipment, transportation, availability of services geographically, cultural and linguistic competency); and

h. Provider capacity (e.g., caseloads, training, staff turnover, provider competency).

4. The Commonwealth shall collect and analyze data from available sources, including, the risk management system described in Section V.C. above, those sources described in Sections V.E-G and I below (e.g., providers, case managers, Quality Service Reviews, and licensing), Quality Management Reviews, the crisis system, service and discharge plans from the Training Centers, service plans for individuals receiving waiver services, Regional Support Teams, and CIMs.

5. The Commonwealth shall implement Regional Quality Councils that shall be responsible for assessing relevant data, identifying trends, and recommending responsive actions in their respective Regions of the Commonwealth.

   a. The councils shall include individuals experienced in data analysis, residential and other providers, CSBs, individuals receiving services, and families, and may include other relevant stakeholders.

   b. Each council shall meet on a quarterly basis to share regional data, trends, and monitoring efforts and plan and recommend regional quality improvement

initiatives. The work of the Regional Quality Councils shall be directed by a DBHDS quality improvement committee.

6. At least annually, the Commonwealth shall report publicly, through new or existing mechanisms, on the availability (including the number of people served in each type of service described in this Agreement) and quality of supports and services in the community and gaps in services, and shall make recommendations for improvement.

E. Providers

1. The Commonwealth shall require all providers (including Training Centers, CSBs, and other community providers) to develop and implement a quality improvement ("QI") program, including root cause analyses, that is sufficient to identify and address significant service issues and is consistent with the requirements of the DBHDS Licensing Regulations at 12 VAC 35-105-620 in effect on the effective date of this Agreement and the provisions of this Agreement.

2. Within 12 months of the effective date of this Agreement, the Commonwealth shall develop measures that CSBs and other community providers are required to report to DBHDS on a regular basis, either through their risk management/critical incident reporting requirements or through their QI program. Reported key indicators shall capture information regarding both positive and negative outcomes for both health and safety and community integration, and will be selected from the relevant domains listed in Section V.D.3. above. The measures will be monitored and reviewed by the DBHDS quality improvement committee, with input from Regional Quality Councils, described in Section V.D.5 above. The DBHDS quality improvement committee will assess the validity of each measure at least annually and update measures accordingly.

3. The Commonwealth shall use Quality Service Reviews and other mechanisms to assess the adequacy of providers' quality improvement strategies and shall provide technical assistance and other oversight to providers whose quality improvement strategies the Commonwealth determines to be inadequate.

F. Case Management

1. For individuals receiving case management services pursuant to this Agreement, the individual's case manager shall meet with the individual face-to-face on a regular basis and shall conduct regular visits to the individual's residence, as dictated by the individual's needs.

2. At these face-to-face meetings, the case manager shall: observe the individual and the individual's environment to assess for previously unidentified risks, injuries, needs, or other changes in status; assess the status of previously identified risks, injuries, needs, or other change in status; assess whether the individual's support plan is being implemented appropriately and remains appropriate for the individual; and ascertain whether supports and services are being implemented consistent with the individual's strengths and preferences and in the most integrated setting appropriate to the individual's needs. If any of these observations or assessments identifies an

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

3. Within 12 months of the effective date of this Agreement, the individual's case manager shall meet with the individual face-to-face at least every 30 days, and at least one such visit every two months must be in the individual's place of residence, for any individuals who:

    a. Receive services from providers having conditional or provisional licenses;

    b. Have more intensive behavioral or medical needs as defined by the Supports Intensity Scale ("SIS") category representing the highest level of risk to individuals;

    c. Have an interruption of service greater than 30 days;

    d. Encounter the crisis system for a serious crisis or for multiple less serious crises within a three-month period;

    e. Have transitioned from a Training Center within the previous 12 months; or

    f. Reside in congregate settings of 5 or more individuals.

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

5. Within 24 months from the date of this Agreement, key indicators from the case manager's face to face visits with the individual, and the case manager's observations and assessments, shall be reported to the Commonwealth for its review and assessment of data. Reported key indicators shall capture information regarding both positive and negative outcomes for both health and safety and community integration, and will be selected from the relevant domains listed in Section V.D.3 above.

6. The Commonwealth shall develop a statewide core competency-based training curriculum for case managers within 12 months of the effective date of this Agreement. This training shall be built on the principles of self-determination and person-centeredness.

G. Licensing

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

2. Within 12 months of the effective date of this Agreement, the Commonwealth shall have and implement a process to conduct more frequent licensure inspections of community providers serving individuals under this Agreement, including:

a. Providers who have a conditional or provisional license;

b. Providers who serve individuals with intensive medical and behavioral needs as defined by the SIS category representing the highest level of risk to individuals;

c. Providers who serve individuals who have an interruption of service greater than 30 days;

d. Providers who serve individuals who encounter the crisis system for a serious crisis or for multiple less serious crises within a three-month period;

e. Providers who serve individuals who have transitioned from a Training Center within the previous 12 months; and

f. Providers who serve individuals in congregate settings of 5 or more individuals.

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

H. Training

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

2. The Commonwealth shall ensure that the statewide training program includes adequate coaching and supervision of staff trainees. Coaches and supervisors must have demonstrated competency in providing the service they are coaching and supervising.

I. Quality Service Reviews

1. The Commonwealth shall use Quality Service Reviews ("QSRs") to evaluate the quality of services at an individual, provider, and system-wide level and the extent to which services are provided in the most integrated setting appropriate to individuals' needs and choice. QSRs shall collect information through:

a. Face-to-face interviews of the individual, relevant professional staff, and other people involved in the individual's life; and

b. Assessment, informed by face-to-face interviews, of treatment records, incident/injury data, key-indicator performance data, compliance with the service requirements of this Agreement, and the contractual compliance of community services boards and/or community providers.

2. QSRs shall evaluate whether individuals' needs are being identified and met through person-centered planning and thinking (including building on individuals' strengths, preferences, and goals), whether services are being provided in the most integrated setting appropriate to the individuals' needs and consistent with their informed choice, and whether individuals are having opportunities for integration in all aspects of their lives (e.g., living arrangements, work and other day activities, access to community services and activities, and opportunities for relationships with non-paid individuals). Information from the QSRs shall be used to improve practice and the quality of services on the provider, CSB, and system wide levels.

3. The Commonwealth shall ensure those conducting QSRs are adequately trained and a reasonable sample of look-behind QSRs are completed to validate the reliability of the QSR process.

4. The Commonwealth shall conduct QSRs annually of a statistically significant sample of individuals receiving services under this Agreement.

VI. Independent Reviewer

A. The Parties have jointly selected Donald J. Fletcher as the Independent Reviewer for this Settlement Agreement. In the event that the Independent Reviewer resigns or the Parties agree to replace the Independent Reviewer, the Parties will select a replacement. If the Parties are unable to agree on a replacement within 30 days from the date the Parties receive a notice of resignation from the Independent Reviewer, or from the date the Parties agree to replace the Independent Reviewer, they shall each submit the names of up to three candidates to the Court, and the Court shall select the replacement from the names submitted.

B. The Independent Reviewer shall conduct the factual investigation and verification of data and documentation necessary to determine whether the Commonwealth is in compliance with this Settlement Agreement, on a six-month cycle continuing during the pendency of the Agreement. The Independent Reviewer is not an agent of the Court, nor does the Independent Reviewer have any authority to act on behalf of the Court. The Independent Reviewer may hire staff and consultants, in consultation with and subject to reasonable objections by the Parties, to assist in his compliance investigations. The Independent Reviewer and any hired staff or consultants are neither agents nor business associates of the Commonwealth or DOJ.

C. The Independent Reviewer shall file with the Court a written report on the Commonwealth's compliance with the terms of this Agreement within 60 days of the close of each review cycle. The first report shall be filed nine months from the effective date of this Agreement. With the consent of the Court, the Court will hold a status conference after the filing of each written report. The Independent Reviewer shall provide the Parties a draft of his/her report at least 21 days before issuing the report. The Parties shall have 14 days to review and comment on the proposed report before it is filed with the Court. The Parties may agree to allow the Independent Reviewer an additional 20 days to finalize a report after he/she receives comments from the Parties, and such an agreement does not require Court approval. In preparing the report, the Independent

Reviewer shall use appendixes or other methods to protect confidential information so that the report itself may be filed with the Court as a public document. Either Party may file a written report with the Court noting its objections to the portions of the Independent Reviewer's report with which it disagrees. The Commonwealth shall publish and maintain these reports on the DBHDS website.

D. The Independent Reviewer, and any hired staff or consultants, may:

1. Have ex parte communications with the Court upon the Court's request or with the consent of the Parties.

2. Have ex parte communications with the Parties at any time.

3. Request meetings with the Parties and the Court.

4. Speak with stakeholders with such stakeholders' consent, on a confidential basis or otherwise, at the Independent Reviewer's discretion.

5. Testify in this case regarding any matter relating to the implementation or terms of this Agreement, including the Independent Reviewer's observations and findings.

6. Offer to provide the Commonwealth with technical assistance and, with the Commonwealth's consent, provide such technical assistance, relating to any aspect of this Agreement or its stated purposes.

7. Conduct regular meetings with both Parties. The purpose of these meetings shall include, among other things, to prioritize areas for the Independent Reviewer to review, schedule visits, discuss areas of concern, and discuss areas in which technical assistance may be appropriate.

E. The Independent Reviewer and any hired staff or consultants shall not be liable for any claim, lawsuit, or demand arising out of their duties under this Agreement. This paragraph does not apply to any proceeding before this Court for enforcement of payment of contracts or subcontracts for reviewing compliance with this Agreement.

F. The Independent Reviewer and any hired staff or consultants shall not be subject to formal discovery, including, but not limited to, deposition(s), request(s) for documents, request(s) for admissions, interrogatories, or other disclosures. The Parties are not entitled to access the Independent Reviewer's records or communications, or those of his/her staff and consultants, although the Independent Reviewer may provide copies of records or communications at the Independent Reviewer's discretion. The Court may review all records of the Independent Reviewer at the Court's discretion.

G. In order to determine compliance with this Agreement, the Independent Reviewer and any hired staff or consultants shall have full access to persons, employees, residences, facilities, buildings, programs, services, documents, records, including individuals' medical and other records, in unredacted form, and materials that are necessary to assess the Commonwealth's compliance with this Agreement, to the extent they are within the State's custody or control. This shall include, but not be limited to, access to the data and

records maintained by the Commonwealth pursuant to Section V above. The provision of any information to the Independent Reviewer pursuant to this Agreement shall not constitute a waiver of any privilege that would otherwise protect the information from disclosure to third parties. The Independent Reviewer and any hired staff or consultants may also interview individuals receiving services under this Agreement with the consent of the individual or his/her authorized representative. Access to CSBs and private providers and entities shall be at the sole discretion of the CSB or private provider or entity; however, the Commonwealth shall encourage CSBs and private providers and other entities to provide such access and shall assist the Independent Reviewer in identifying and contacting them. The Independent Reviewer shall exercise his/her access to Commonwealth employees and individuals receiving services under this Agreement in a manner that is reasonable and not unduly burdensome to the operation of Commonwealth agencies and that has minimal impact on programs or services being provided to individuals receiving services under this Agreement. Such access shall continue until the Agreement is terminated. The Parties agree that, in cases of an emergency situation that present an immediate threat to life, health, or safety of individuals, the Independent Reviewer will not be required to provide the Commonwealth notice of such visit or inspection. Any individually identifying health information that the Independent Reviewer and any hired staff or consultants receive or maintain shall be kept confidential.

H. Budget of the Independent Reviewer

1. Within 45 days of appointment, the Independent Reviewer shall submit to the Court for the Court's approval a proposed budget for State Fiscal Year 2013. Using the proposed budget for State Fiscal Year 2013, the Independent Reviewer shall also propose an equivalent amount prorated through the remainder of State Fiscal Year 2012 as the budget for State Fiscal Year 2012.

2. The Independent Reviewer shall provide the Parties a draft of the proposed budget at least 30 days in advance of submission to the Court. The Parties shall raise with the Independent Reviewer any objections they may have to the draft of the proposed budget within 10 business days of its receipt. If the objection is not resolved before the Independent Reviewer's submission of a proposed budget to the Court, a Party may file the objection with the Court within 10 business days of the submission of the proposed budget to the Court. The Court shall consider such objections and make any adjustments it deems appropriate prior to approving the budget.

3. Thereafter, the Independent Reviewer shall submit annually a proposed budget to the Court for its approval by April 1 in accordance with the process set forth above.

4. At any time, the Independent Reviewer may submit to the Parties for approval a proposed revision to the budget, along with any explanation of the reason for the proposed revision. Should the Parties and Independent Reviewer not be able to agree on the proposed revision, the Court will be notified as set forth in Section V.H.2 above.

5. The approved budget of the Independent Reviewer shall not exceed $300,000 in any State Fiscal Year during the pendency of this Agreement, inclusive of any costs and expenses of hired staff and consultants, without the approval of the Commonwealth or the Court pursuant to Sections V.H.2. or H.4. above.

I. Reimbursement and Payment Provisions

1. The cost of the Independent Reviewer, including the cost of any consultants and staff to the Reviewer, shall be borne by the Commonwealth in this action up to the amount of the approved budget for each State Fiscal Year. All reasonable expenses incurred by the Independent Reviewer in the course of the performance of his/her duties as set forth in this Agreement shall be reimbursed by the Commonwealth. In no event will the Commonwealth reimburse the Independent Reviewer for any expense that exceeds the approved fiscal year budget or the amount approved under Sections V.H.4 or H.5 above. The Court retains the authority to resolve any dispute that may arise regarding the reasonableness of fees and costs charged by the Reviewer. The United States shall bear its own expenses in this matter. If a dispute arises regarding reasonableness of fees or costs, the Independent Reviewer shall provide an accounting justifying the fees or costs.

2. The Independent Reviewer shall submit monthly statements to DBHDS, with copies to the United States and the Court, detailing all expenses the Independent Reviewer incurred during the prior month. DBHDS shall issue payment in accordance with the monthly statement as long as such payment is within the approved State Fiscal Year budget. Such payment shall be made by DBHDS within 10 business days of receipt of the monthly statement. Monthly statements shall be provided to: Assistant Commissioner for Developmental Services, DBHDS, P.O. Box 1797, Richmond, Virginia 23238-1797.

3. In the event that, upon a request by the United States or the Independent Reviewer, the Court determines that the Commonwealth is unreasonably withholding or delaying payment, or if the Parties agree to use the following payment procedure, the following payment procedure will be used:

    a. The Commonwealth shall deposit $100,000.00 into the Registry of the Court as interim payment of costs incurred by the Independent Reviewer. This deposit and all other deposits pursuant to this Order shall be held in the Court Registry Investment System and shall be subject to the standard registry fee imposed on depositors.

    b. The Court shall order the clerk to make payments to the Independent Reviewer. The clerk shall make those payments within 10 days of the entry of the Order directing payment. Within 45 days of the entry of each Order directing payment, the Commonwealth shall replenish the fund with the full amount paid by the clerk in order to restore the fund's total to $100,000.00.

J. The Independent Reviewer, including any hired staff or consultants, shall not enter into any contract with the Commonwealth while serving as the Independent Reviewer. If the

Independent Reviewer resigns from his/her position as Independent Reviewer, he/she may not enter into any contract with the Commonwealth on a matter related to this Agreement during the pendency of this Agreement without the written consent of the United States.

K. Other than the semi-annual compliance report pursuant to Section VI.C above or proceedings before the Court, the Independent Reviewer, and any hired staff or consultants, shall refrain from any public oral or written statements to the media, including statements "on background," regarding this Agreement, its implementation, or the Commonwealth's compliance. In addition, the Independent Reviewer shall not establish or maintain a website regarding this Agreement, its implementation, or the Commonwealth's compliance.

VII. Construction and Termination

A. The Parties agree jointly to file this Agreement with the United States District Court for the Eastern District of Virginia, Richmond Division.

B. The Parties anticipate that the Commonwealth will have complied with all provisions of the Agreement by the end of State Fiscal Year 2021. Compliance is achieved where any violations of the Agreement are minor or incidental and are not systemic. The Court shall retain jurisdiction of this action for all purposes until the end of State Fiscal Year 2021 unless:

1. The Parties jointly ask the Court to terminate the Agreement before the end of State Fiscal Year 2021, provided the Commonwealth has complied with this Agreement and maintained compliance for one year; or

2. The United States disputes that the Commonwealth is in compliance with the Agreement at the end of State Fiscal Year 2021. The United States shall inform the Court and the Commonwealth by January 1, 2021, that it disputes compliance, and the Court may schedule further proceedings as appropriate. The Party that disagrees with the Independent Reviewer's assessment of compliance shall bear the burden of proof.

C. The burden shall be on the Commonwealth to demonstrate compliance to the United States pursuant to Section VII.B.1 above. If the Commonwealth believes it has achieved compliance with a portion of this Agreement and has maintained compliance for one year, it shall notify the United States and the Independent Reviewer. If the United States agrees, the Commonwealth shall be relieved of that portion of the Settlement Agreement and notice of such relief shall be filed with the Court. The Parties may instead agree to a more limited review of the relevant portion of the Agreement.

D. With the exception of conditions or practices that pose an immediate and serious threat to the life, health, or safety of individuals receiving services under this Agreement, if the United States believes that the Commonwealth has failed to fulfill any obligation under this Agreement, the United States shall, prior to initiating any court proceeding to remedy such failure, give written notice to the Commonwealth which, with specificity, sets forth the details of the alleged noncompliance.

1. With the exception of conditions or practices that pose an immediate and serious threat to the life, health, or safety of individuals covered by this Agreement, the Commonwealth shall have forty-five (45) days from the date of such written notice to respond to the United States in writing by denying that noncompliance has occurred, or by accepting (without necessarily admitting) the allegation of noncompliance and proposing steps that the Commonwealth will take, and by when, to cure the alleged noncompliance.

2. If the Commonwealth fails to respond within 45 days or denies that noncompliance has occurred, the United States may seek an appropriate judicial remedy.

3. If the Commonwealth timely responds by proposing curative action by a specified deadline, the United States may accept the Commonwealth's proposal or offer a counterproposal for a different curative action or deadline, but in no event shall the United States seek an appropriate judicial remedy for the alleged noncompliance until after the time provided for the Commonwealth to respond under Section VII.D.2 above. If the Parties fail to reach agreement on a plan for curative action, the United States may seek an appropriate judicial remedy.

4. Notwithstanding the provisions of this Section, with the exception of conditions that pose an immediate and serious threat to the life, health, or safety of individuals receiving services under this Agreement, the United States shall neither issue a noncompliance notice nor seek judicial remedy for the nine months after the effective date of this Agreement.

E. If the United States believes that conditions or practices within the control of the Commonwealth pose an immediate and serious threat to the life, health, or safety of individuals in the Training Centers or individuals receiving services pursuant to this Agreement, the United States may, without further notice, initiate a court proceeding to remedy those conditions or practices.

F. This Agreement shall constitute the entire integrated Agreement of the Parties.

G. Any modification of this Agreement shall be executed in writing by the Parties, shall be filed with the Court, and shall not be effective until the Court enters the modified agreement and retains jurisdiction to enforce it.

H. The Agreement shall be applicable to, and binding upon, all Parties, their employees, assigns, agents, and contractors charged with implementation of any portion of this Agreement, and their successors in office. If the Commonwealth contracts with an outside provider for any of the services provided in this Agreement, the Agreement shall be binding on any contracted parties, including agents and assigns. The Commonwealth shall ensure that all appropriate Commonwealth agencies take any actions necessary for the Commonwealth to comply with provisions of this Agreement.

I. The Commonwealth, while empowered to enter into and implement this Agreement, does not speak for the Virginia General Assembly, which has the authority under the Virginia Constitution and laws to appropriate funds for, and amend laws pertaining to, the Commonwealth's system of services for individuals with developmental disabilities. The

Commonwealth shall take all appropriate measures to seek and secure funding necessary to implement the terms of this Agreement. If the Commonwealth fails to attain necessary appropriations to comply with this Agreement, the United States retains all rights to enforce the terms of this Agreement, to enter into enforcement proceedings, or to withdraw its consent to this Agreement and revive any claims otherwise barred by operation of this Agreement.

J. The United States and the Commonwealth shall bear the cost of their fees and expenses incurred in connection with this case.

VIII. General Provisions

A. The Commonwealth agrees that it shall not retaliate against any person because that person has filed or may file a complaint, provided assistance or information, or participated in any other manner in the United States' investigation or the Independent Reviewer's duties related to this Agreement. The Commonwealth agrees that it shall timely and thoroughly investigate any allegations of retaliation in violation of this Agreement and take any necessary corrective actions identified through such investigations.

B. If an unforeseen circumstance occurs that causes a failure to timely fulfill any requirement of this Agreement, the Commonwealth shall notify the United States and the Independent Reviewer in writing within 20 calendar days after the Commonwealth becomes aware of the unforeseen circumstance and its impact on the Commonwealth's ability to perform under the Agreement. The notice shall describe the cause of the failure to perform and the measures taken to prevent or minimize the failure. The Commonwealth shall take reasonable measures to avoid or minimize any such failure.

C. Failure by any Party to enforce this entire Agreement or any provision thereof with respect to any deadline or any other provision herein shall not be construed as a waiver, including of its right to enforce other deadlines and provisions of this Agreement.

D. The Parties shall promptly notify each other of any court or administrative challenge to this Agreement or any portion thereof, and shall defend against any challenge to the Agreement.

E. Except as provided in this Agreement, during the pendency of the Agreement, the United States shall not file suit under the ADA or CRIPA for any claim or allegation set forth in the complaint.

F. The Parties represent and acknowledge this Agreement is the result of extensive, thorough and good faith negotiations. The Parties further represent and acknowledge that the terms of this Agreement have been voluntarily accepted, after consultation with counsel, for the purpose of making a full and final compromise and settlement of any and all claims arising out of the allegations set forth in the Complaint and pleadings in this Action, and for the express purpose of precluding any further or additional claims arising out of the allegations set forth in the Complaint and pleadings in this Action. Each Party to this Agreement represents and warrants that the person who has signed this Agreement on behalf of his or her entity is duly authorized to enter into this Agreement and to bind

that Party to the terms and conditions of this Agreement.

G. Nothing in this Agreement shall be construed as an acknowledgement, an admission, or evidence of liability of the Commonwealth under federal or state law, and this Agreement shall not be used as evidence of liability in this or any other civil or criminal proceeding.

H. This Agreement may be executed in counterparts, each of which shall be deemed an original, and the counterparts shall together constitute one and the same agreement, notwithstanding that each Party is not a signatory to the original or the same counterpart.

I. "Notice" under this Agreement shall be provided to the following or their successors:

For the United States:

Chief of the Special Litigation Section
United States Department of Justice
Civil Rights Division
601 D Street, N.W.
Washington, D.C. 20004

For the Commonwealth:

Attorney General of Virginia
900 E. Main Street
Richmond, VA 23219

Counsel to the Governor
Patrick Henry Building, 3rd Floor
1111 E. Broad Street
Richmond, VA 23219

For the Independent Reviewer:

Donald J. Fletcher
P.O. Box 54
16 Cornwell Road
Shutesbury, MA 01072-0054

IX. Implementation of the Agreement

A. The implementation of this Agreement shall begin immediately upon the Effective Date, which shall be the date on which this Agreement is approved and entered as an order of the Court.

B. Within one month from the Effective Date of this Agreement, the Commonwealth shall appoint an Agreement Coordinator to oversee compliance with this Agreement and to serve as a point of contact for the Independent Reviewer.

C. The Commonwealth shall maintain sufficient records to document that the requirements of this Agreement are being properly implemented and shall make such records available

to the Independent Reviewer for inspection and copying upon request and on a reasonable basis.

D. The Commonwealth shall notify the Independent Reviewer and the United States promptly upon the unexplained or unexpected death or serious physical injury resulting in on-going medical care of any individual covered by this Agreement. The Commonwealth shall, via email, forward to the United States and the Independent Reviewer electronic copies of all completed incident reports and final reports of investigations related to such incidents, as well as any autopsies and death summaries in the State's possession. The provision of any information to the Independent Reviewer and the United States pursuant to this Agreement shall not constitute a waiver of any privilege that would otherwise protect the information from disclosure to third parties.

E. The United States shall have full access to persons, employees, residences, facilities, buildings, programs, services, documents, records, and materials that are within the control and custody of the Commonwealth and are necessary to assess the Commonwealth's compliance with this Agreement and/or implementation efforts.

1. Such access shall include departmental and/or individual medical and other records in unredacted form.

2. The United States shall provide notice at least one week in advance of any visit or inspection.

3. The Parties agree that, in cases of an emergency situation that presents an immediate threat to life, health, or safety of individuals, the United States will be required to provide the Commonwealth with sufficient notice of such visit or inspection as to permit a Commonwealth representative to join the visit.

4. Such access shall continue until this case is dismissed.

5. The Commonwealth shall provide to the United States, as requested, in unredacted form, any documents, records, databases, and information relating to the implementation of this Agreement as soon as practicable, but no later than within thirty (30) business days of the request, or within a time frame negotiated by the Parties if the volume of requested material is too great to reasonably produce within thirty days.

6. The provision of any information to the United States pursuant to this Agreement shall not constitute a waiver of any privilege that would otherwise protect the information from disclosure to third parties.

FOR THE UNITED STATES:

NEIL H. MacBRIDE
United States Attorney
Eastern District of Virginia

ROBERT McINTOSH
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600 East Main St., Suite 1800
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(804) 819-5400
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VA Bar #66113

Respectfully submitted,

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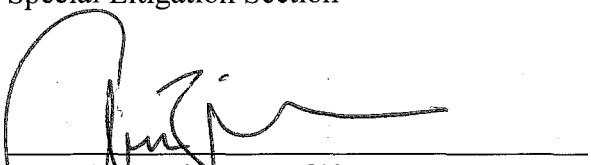
Assistant Attorney General
Civil Rights Division

EVE HILL
Senior Counselor

ALISON N. BARKOFF
Special Counsel for Olmstead Enforcement
Civil Rights Division

JONATHAN SMITH
Chief
Special Litigation Section



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FOR THE COMMONWEALTH:

WILLIAM A. HAZEL, JR., M.D.
Secretary of Health and Human Resources
on Behalf of Governor Robert F. McDonnell

KENNETH T. CUCCINELLI, II
as Attorney General of Virginia pursuant to Virginia Code § 2.2-514

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Virginia State Bar No. 41982

ENTERED THIS ____ day of _____, 2012.

_____
UNITED STATES DISTRICT JUDGE

APPENDIX B

Secretary for Health and Human Resources Plan for Implementation of *Settlement Agreement*

COMMONWEALTH of VIRGINIA

Office of the Governor

William A. Hazel, Jr., MD
Secretary of Health and Human Resources

February 13, 2012

The Honorable Lacey E. Putney, Chair
House Appropriations Committee
General Assembly Building
P.O. Box 406
Richmond, Virginia 23218

Dear Delegate Putney,

Pursuant to amended §37.2-319 of the Code of Virginia relating to the administration of the Behavioral Health and Developmental Services Trust Fund, attached is the plan to transition individuals from state training centers to community-based settings.

I appreciate your patience in allowing our office additional time to prepare the report as we were negotiating with the U.S. Department of Justice.

If you have any questions, feel free to contact me.

Sincerely,

William A. Hazel, Jr., M.D.

Enclosure
Cc: James W. Stewart, III
Cindi Jones

WAH/klb

COMMONWEALTH of VIRGINIA

Office of the Governor

William A. Hazel, Jr., MD
Secretary of Health and Human Resources

February 13, 2012

The Honorable Walter A. Stosch, Chair
Senate Finance Committee
10th Floor, General Assembly Building
910 Capitol Street
Richmond, Virginia 23218

Dear Senator Stosch,

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COMMONWEALTH of VIRGINIA

Office of the Governor

William A. Hazel, Jr., MD
Secretary of Health and Human Resources

February 13, 2012

The Honorable Robert F. McDonnell
Governor of Virginia
Patrick Henry Building
P.O. Box 145
Richmond, Virginia 23219

Dear Governor McDonnell,

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Executive Summary

This document outlines the Secretary of Health and Human Resources' plan to transform the system of care for individuals with intellectual disability in the Commonwealth of Virginia, in accordance with amended §37.2-319 of the Code of Virginia relating to the administration of the Behavioral Health and Developmental Services Trust Fund.[1] The Trust Fund plan lays out a roadmap to accelerate Virginia's move away from reliance on five large training centers to provide care for individuals with intellectual disability and toward a more fully-integrated community-based system of services and supports for both individuals with intellectual and other developmental disabilities. The plan was developed after careful consideration of the following factors: the declining census in training centers, aging facility infrastructure, nationwide best practices, an improving community-based services infrastructure, and Virginia's recent settlement agreement with the US Department of Justice. Collectively, these factors support decisions outlined in this Trust Fund plan. Specifics include:

- With a declining training center census, Virginia operates more training centers than it needs. Census among the training centers has decreased 42 percent since FY2000;
- All but one of Virginia's training centers is more than 35 years old and have significant infrastructure needs in order to maintain the facilities;
- Nationally, Virginia ranks fourth in the number of individuals with intellectual disability in large settings like training centers (37%) and ranks 48th in the number of individuals served in smaller, community-based settings with fewer than 15 people (63.4%); and,
- Virginia recently entered into a ten year court-enforced settlement agreement with the US Department of Justice requiring the Commonwealth to make significant changes to its system of care for individuals with intellectual and other developmental disabilities.

The plan requires Virginia to:

- Continue downsizing Southeastern Virginia Training Center (SEVTC) to 75 beds;
- Cease admissions and close Southside Virginia Training Center (SVTC), Northern Virginia Training Center (NVTC), Southwestern Virginia Training Center (SWVTC), and Central Virginia Training Center (CVTC) over a 10 year period;
- Improve discharge processes and family education to ensure a smooth and safe discharge process for every individual transitioning from a training center to the community;
- Ensure community-based crisis intervention and stabilization programs are firmly in place;
- Increase the number of waiver slots available to transition individuals and prevent unnecessary institutionalization of those on the wait list for services;
- Significantly improve oversight and quality of community-based services; and,
- Develop specialized medical and dental services in the community for individuals with intellectual disability.

[1] Chapter 724, Acts of Assembly, 2011

Introduction

The plan to reform and strengthen the system of care for individuals with intellectual and other developmental disabilities outlines the context for proposing to close four of five of Virginia's training centers. It also describes the activities that will be undertaken by the Department of Behavioral Health and Developmental Services (DBHDS), and the Department of Medical Assistance Services (DMAS), and other state agencies to expand the community-based services system to ensure appropriate and safe transitions for individuals currently residing at the training centers.

National Trends and Initiatives

The proposals to expand the community-based system of supports and services and close training centers are consistent with national trends and legal mandates, such as:

- The Supreme Court ruling in *Olmstead v. L.C.*. The ruling supported that unjustified isolation of individuals with disabilities is a form of unlawful discrimination under the Americans with Disabilities Act;
- Virginia's settlement agreement with the US Department of Justice, which requires significant expansion of the community-based system of services for individuals with intellectual and other developmental disabilities over a ten year period;
- The Federal Developmental Disabilities Act which requires that individuals with intellectual and other developmental disabilities must have access to opportunities and supports to live a fully integrated community life with access to employment, homes, relationships, and other aspects of community life;
- The nationwide trend to decrease reliance on large institutions to provide supports to individuals with intellectual disability. Virginia is one of only 13 states with more than 1000 people living in large institutions;
- Recent research that finds the quality of life for individuals that transition from large institutions to community-based settings improves in terms of daily living skills, social development, and communication skills.

Virginia's Current System for Supporting Individuals with Intellectual Disability

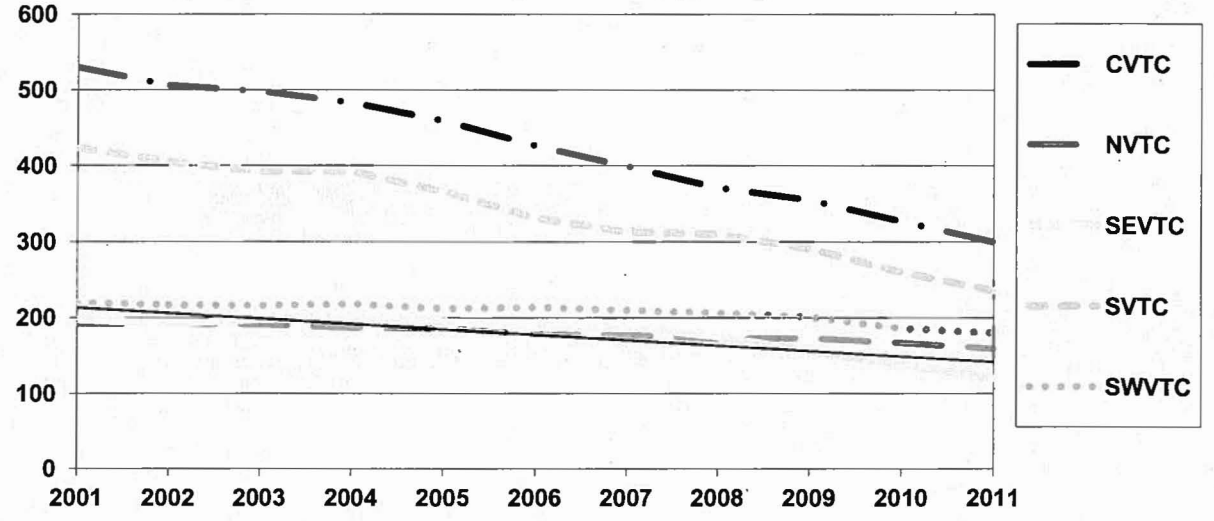
Virginia has five large institutions that serve individuals with intellectual disability (Table 1). Today, these five training centers have a collective census of approximately 1018 individuals. This census is a reduction from over 5000 individuals in residence in the 1970s. Figure 1 shows the decline in census over the last ten years, from 1635 residents in FY2000 to less than 1100 today.

Table 1: Census of Virginia's Five Training Centers (January 2012)

Training Center	Census
Central Virginia Training Center (CVTC)	357
Northern Virginia Training Center (NVTC)	152
Southeastern Virginia Training Center (SEVTC)	111
Southside Virginia Training Center (SVTC)	224
Southwestern Virginia Training Center (SWVTC)	174
Total	1018

The overall decline in census is the result of two complementary trends. First, more individuals are choosing to leave training centers and move to group homes, community intermediate care facilities (ICFs), or other settings. Over the last five years, an average of 56 individuals each year move from Virginia's training centers to community settings.

Figure 1: Annual Census at Virginia's Training Centers



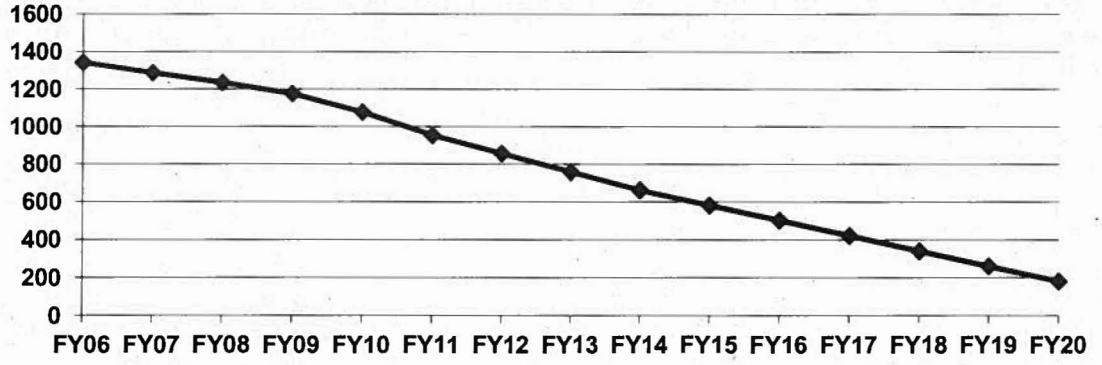
The second trend has been the virtual elimination of long-term, regular admissions to training centers because families today are choosing to keep their loved ones in the community with appropriate supports at home or in community congregate settings. These long-term, regular admissions are those extending more than 75 days.[2] Since 2007, there has been an average of 12.6 long-term, regular admissions per year for all five training centers. On a more frequent

[2] 12VAC35-190-10-51. Regulations for Admissions to Training Centers.

basis, training centers continue to admit individuals requiring respite care for less than 21 days or emergency care for less than 75 days.[3] According to recent DBHDS data over the last six years there was an average of 42 emergency admissions and 66 respite admissions to training centers. Training centers and Community Services Boards partner together to ensure that these admissions are time limited and used only as a last resort to community options. In this manner, long-term stays are generally avoided and individuals return to the community in less than 75 days.

Given these trends, conservative estimates show that Virginia's five training centers will house less than 600 individuals in FY2015 and less than 300 individuals by FY2019 (Figure 2).

Figure 2: Training Center Projected Census



With fewer and fewer individuals and families choosing training centers for their care, Virginia's community system serving individuals with intellectual disability has grown in the last three decades. Virginia has made significant progress in providing adequate and appropriate individualized services to persons with intellectual disability in the community through a Medicaid Intellectual Disability (ID) Waiver. Today, over 8,600 individuals receive the support of this important resource to live and receive assistance in the community. However, over 5,900 families in Virginia are currently on the waiting list for a Medicaid ID Waiver slot, with more than 3,200 of these families having been determined to be in urgent need of services. These individuals and families have opted to wait for community ID Medicaid Waiver slots as opposed to seeking admission to one of Virginia's training centers or a community-based Intermediate Care Facility. (ICF/MR).

Given the demands on Virginia's community-based system of care for individuals with intellectual disability, recent study groups and commissions established by the General Assembly have called for a move toward greater capacity to serve these individuals in the community and a

[3] 12VAC35-200-10-30. Regulations for Emergency and Respite Admissions to Training Centers.

much smaller role for Virginia's training centers.[4] The economics of community-based and facility-based care support the recommendations of these studies and commissions. The annual cost of serving one person in a Virginia state ICF/MR training center today averages $216,000, which includes direct services, administrative supports and high infrastructure requirements. As the census of each training center drops, the average cost will go up. The cost per person for those living in the community is as follows:

- A community based ICF/MR, that provides the same range of services provided currently to those who live in training centers, averages $138,000 per person per year; and
- The average cost of ID Medicaid Waiver plan of care for a person who lives in a community group home is $95,000 per person per year.

Closure Timeframes and Process

This plan outlines the activities required to reduce the number of individuals residing in training centers and identifies facility- specific objectives and timeframes to implement changes. The plan employs a 10 year timeframe to downsize and close four of Virginia's five training centers, in order to effectively execute Virginia's settlement agreement with DOJ. SEVTC, with capacity to serve 75 individuals, will remain open to serve those with the most significant long-term medical and behavioral needs. Table 2 shows the projected facility-specific reduction targets and timeframes for downsizing. The table shows projected closures of SVTC in FY15, NVTC in FY16, SWVTC in FY18, and CVTC in FY20.

Table 2: Training Center Downsizing and Closure Projections

Fiscal Year	SVTC	NVTC	SWVTC	CVTC	SEVTC*	Estimated Waiver Slots Required**
2012	40			20	45	60***
2013	97	51		25		160
2014	97	51		25		160
2015		50		48		90
2016			58	48		85
2017			58	48		90

[4] *"The Cost and Feasibility of Alternatives to the State's Five Mental Retardation Training Centers,"* House Document 76, 2005; and *"Report of the Study of the Mental Retardation System in Virginia,"* Item 311AA of the 2007 Appropriations Act, October 2007.

2018	58	48	90
2019		48	35
2020		47	35

*SEVTC will be reduced from its current census of 120 to 75 as part of the 2009 General Assembly SEVTC downsizing project.

**An annual natural death rate is factored into the waiver slots estimate.

***30 slots for the SEVTC downsizing project are already available.

It is estimated that 805 ID waiver slots for the facility population must be established in order to meet these downsizing targets and ensure closure. The 805 slots factor in an average natural death rate of approximately 10 individuals per year and anticipates that some individuals will choose small ICFs or Money Follows the Person (MFP) waiver placements.

Closure Process

In order to meet these closure targets, DBHDS must ensure that the current discharge processes at training centers are improved to ensure safe and effective discharges. DBHDS must work with families and staff at training centers to ensure they are informed about the current options available in the community. DBHDS is taking the following actions:

- Transition Team -- a team of individuals will be working with individuals and families to support them during transition. This team will include the facility director, social work director, social workers, discharge coordinators, and other training staff. In addition, CSB case managers will work closely to connect with each individual and family to ensure continuity of communication during the discharge process.
- Education and Informed Decision-Making -- To ensure that individuals and Authorized Representatives understand the specific closure plans for the training center where their loved one lives, members of the transition team will hold Personal Support Team (PST) meetings with families to describe the process and outline the steps that will be taken to develop an appropriate discharge plan and begin to identify potential community placements. The PST includes the individual, Authorized Representative/family member/guardian, the CSB, direct support staff, clinical professionals who know the individual, and other training center staff.
- Discharge Plan – The goal of the first PST meeting is to review the transition planning process and identify the essential supports and services and personal preferences identified in the person-centered plan. The PST reviews and establishes identified outcomes and specific actions needed to support the individual to better live and function within the community. The PST then agrees upon a discharge plan.
- Transition to the Community – The team will work with individuals to help identify providers who are qualified to deliver services and contact them to discuss potential services that would

achieve the personal outcomes identified in the discharge plan. Among the options will be opportunities for individuals to meet and interview providers through provider fairs as well as more individualized visits. Once the providers are selected, the process of beginning to establish community connections and visits to the new home, preferred day activity and community resources will be initiated and a move date will be identified. The roles and responsibilities during the transition will be outlined in the discharge plan, and resources prepared for transition. The training center social worker in coordination with the CSB case manager will ensure all activities related to the move are completed prior to the transition.

- Community Follow-up -- In addition to the monitoring of health and safety that occurs for all individuals in the community, a series of reviews will be conducted at 30, 60, and 90 day intervals and annually thereafter for those individuals who have transitioned to the community. Monitoring will be completed by a team of comprised training center staff who know the individual and the individual's case manager. The team will be responsible for ensuring the individual's outcomes are being met and the transition continues to be successful.

Employees

DBHDS is committed to establishing and implementing employee supports and resources that promote workforce stability and provide opportunities to determine their future. Employee retention during the closure and transition process is, and will remain, a high priority to assure continuity of services to the individuals we serve. Special meetings will be held between management and employees on all shifts at each facility. These meetings will provide an opportunity for the employees and DBHDS to discuss closure issues and the needs of employees.

DBHDS will work closely with the leadership of each training center to begin implementation of the following resources (below) for their employees. There are training centers that will be closed on or before 2015 so it is essential to work most closely with these employees first (such as SVTC and NVTC). These resources will be established as necessary at other training centers in later years to provide transitional resources to employees on those campuses.

Workforce Development and Resource Center

Training center employees will be surveyed to obtain information on their future employment interests, including relocation to other DBHDS facilities; and to solicit from them the resources and assistance they believe they will need during the closure process.

A Workforce Development and Resource Center in collaboration with the Virginia Community College System, Workforce Services, will be established at training centers to provide personal support and assistance for each employee in identifying employment options.

The Center will be accessible to staff on all shifts and provide activities that will include:

- Career Counseling, to include employee skills inventory assessment, development of resume and assistance with interviewing skills;
- Community services information on various opportunities to serve individuals with disabilities in community settings, and related requirements;
- Computer access for job searches and online application submission;
- Up-to-date lists of job opportunities with the Department of Behavioral Health and Developmental Services and other human services agencies, including community services boards and Private Providers, Psychiatric Hospitals, and local industries.
- Retirement and benefit workshops in collaboration with the Virginia Retirement System and the Virginia Employment Commission; and,
- Personnel-related Question and Answer sessions.

Training center employees will continue to be offered, at no cost, the opportunity to participate in the College of Direct Support Program (CDS) and the Direct Support Professional Career Pathway Program (Career Studies Certificate) in Developmental Disabilities or Behavioral Health), which offers online learning to strengthen the competencies needed to support individuals with disabilities in various settings. Completions of the CDS Program or the Certificate Program not only improve the services provided to individuals with disabilities, but also help to enhance the employee's resume and subsequent marketability. Based on the needs identified by the employees, additional workforce development services may be offered to supplement the training to enhance one's future career objectives.

Opportunities with DBHDS and Other Organizations

Employees at all of Virginia's training centers have acquired the competencies that make them effective in providing services and supports to individuals with disabilities. A great number of employees have committed many years of their lives to providing services and supports to this population and it is hoped that many of them will be interested in continuing their service in the community.

Employees will be encouraged to fill critical positions in community organizations. Assistance with this transition will be supplemented by a DBHDS partnership with CSB's, private providers, and other disability organizations in the region. An additional benefit derived from training center employees transitioning with the individuals we serve to community settings, is that it provides continuity of services, and flexibility in setting employee start dates to ensure training centers retain adequate staffing levels during the facility closures.

Employee Access to Communication

To maintain stability and morale in the workforce, it is critical that accurate and timely communication be sustained throughout the closure process. . The department will ensure that employees are kept informed about progress on the facility closure and about available employment opportunities. Key aspects of this communication include:

- General employee communications via e-mail, staff meetings and postings on employee bulletin boards will be established to provide employees on all shifts with updates on the closure, Career Center announcements, and other related items of interest.
- A link will be established from the training center homepages on the DBHDS Website to provide interested parties with access to notices and information regarding the closure of the facility.
- As needed, employee meetings will be scheduled to provide staff with regular access to training center management for information sharing and support.

Employee Support Advisory Team

DBHDS recognizes the importance of retaining experienced staff at the facility throughout the closure process. To support its goal of ensuring adequate staffing and to assist the employees in developing personal plans for their future, the facility will convene employee support advisory teams. These advisory groups will include representatives of DBHDS staff, and training center employees and management. The advisory teams will help ensure continuity of staffing, that employment assistance activities meet the needs of employees, identify retention and morale-boosting initiatives that encourage the staff to assist in the transition of individuals we serve to the community and the ultimate closure of the facility.

Provisions to Provide a Broad Array of Community-Based Services

Downsizing and closure of four training centers cannot occur without complementary changes to the community-based system of services for individuals with intellectual disability. In order to implement closures and ensure positive outcomes for Virginians with intellectual disability, Virginia must provide the following investments in its community-based system of care:

- Ensure community-based crisis stabilization programs for individuals with intellectual disability are firmly in place;
- Increase the number of waiver slots available to transition individuals and prevent unnecessary institutionalization of those on the wait list for services;
- Expand the capacity of and strengthen oversight of community-based services;
- Develop specialized medical and dental services in the community for individuals with intellectual disability.

Crisis Management System for Individuals with Intellectual Disability

The 2011 General Assembly provided $5M in funding to start a crisis stabilization program for individuals with intellectual disability who have co-occurring mental health disorders or behavioral problems. DBHDS is currently working with the five CSB regions around the state to implement this program. There will be five regional programs that will begin providing services in the spring of 2012. These community based crisis programs use a combination of in-home supports to prevent escalation of crises and out of home crisis respite placements when necessary to stabilization individuals and assist them in returning to their home. These programs will be implemented using the national Systemic Therapeutic Assessment Respite and Treatment (START) model to ensure consistency in operations and to establish statewide coverage.

Increase Waiver Capacity

The 2011 General Assembly requested that DMAS and DBHDS study Virginia's waiver programs serving individuals with intellectual disability and developmental disabilities and provide recommendations on how to modify the program to more appropriately serve individuals in need of community-based services (BBBBB Study). Several previous legislative studies, the DBHDS *Creating Opportunities Plan*, and DOJ have noted that the current waiver program is not sufficient to serve those with the most complex medical and behavioral needs, including many individuals currently living at training centers.

The BBBBB study, developed in consultation with stakeholders, describes some short-term modifications to the current waiver programs that can assist with transitioning individuals from training centers to the community. The study also outlines some long-term reform options that both organizations must further consider, in consultation with stakeholders, prior to the DD waiver renewal in 2013 and the ID waiver renewal in 2014.

In tandem with any modifications to the waiver programs, the number of waiver slots available to individuals with intellectual and developmental disabilities must be expanded in order to provide adequate capacity to close four training centers and prevent unnecessary institutionalization of individuals on the waiver wait lists. At the time of report, there are 5,932 individuals on the ID waiver wait list and 1,200 on the DD waiver wait list. In addition and as mentioned previously, an estimated 805 ID waiver slots must be created to transition individuals currently residing in training centers to the community over the next 10 years. The DOJ settlement agreement provides 2,915 community ID waiver slots over the term of the agreement and 450 DD waiver slots to begin to address these needs. The agreement also requires an Individual and Family Supports Program to assist up to 1000 individuals that remain on the wait list for services.

Improve Oversight of Community-Based Services

Improving and building upon Virginia's current system of quality assurance and monitoring must occur in order to ensure appropriate oversight of community-based services for individuals transitioning from training centers to the community, those coming off the wait list for services, and those already receiving services. Additional staff will be required for DBHDS and DMAS and includes additional licensing specialists, human rights advocates, community resource consultants, and prior authorization consultants. DMAS must add staff to monitor waiver implementation and community expansion of services. DBHDS estimates that 1-2 FTEs needs to be added per every 100 waiver slots established in order to appropriately monitor services in the community, particularly for individuals transitioned to the community from training centers.[5]

Additional DBHDS staff and other agencies will work with community providers and CSBs to implement provider risk management and quality improvement processes and ensure critical incidents, deaths, and serious injuries are reported consistently to DBHDS and other authorities as appropriate for follow-up and corrective action. The Commonwealth will also employ a minimum number of additional staff to collect data about individuals receiving services and analyze outcomes related to safety, harm, physical, mental, and behavioral health, crisis avoidance, stability in placements, choice, access to services, and other areas.

DBHDS will also establish Regional Quality Councils to meet quarterly and assess the relevant data, identify trends, and recommend responsive actions for each Health Planning Region. Regional Quality Councils will be comprised of individuals experienced in data analysis, residential and other providers, CSBs, individual receiving services, and families, and others. The DBHDS Quality Improvement Committee will be established to direct the work of the Regional Quality Councils. These will serve as an additional layer of oversight to ensure each Region is examining problems and working to improve them.

As part of additional oversight and monitoring, both case managers and licensing must prioritize working with high-risk individuals on a monthly or more frequent basis to ensure their needs are met and they are not experiencing unnecessary risk. Those individuals who are high-risk include those receiving services from a provider with a conditional or provisional license, those with high medical or behavioral needs, those with frequent crises or interruptions in service, those who have recently transitioned from training centers, and those residing in congregate settings of 5 or more individuals.

Specialized, Community-Based Medical and Dental Services

A frequent concern raised on behalf of individuals residing in training centers as well as those in the community is the lack of sufficient, specialized medical and dental services for individuals with intellectual disability and developmental disabilities. It is difficult to locate clinicians in the

[5] 1 DBHDS FTE per 100 waiver slots is based on HD 216 (2009) estimate.

community who are knowledgeable about the complexities and challenges associated with serving individuals with ID who need psychiatric consultation, behavioral consultation, dental care, and general medical care. Over the last decade, DBHDS has developed limited specialized services on the grounds of the five training centers that are available to individuals with intellectual disability who live in the community. These Regional Community Support Centers (RCSC) receive minimal state general funds on an annual basis and utilize the services of the training center medical and dental professionals to provide care to individuals that come to the RCSCs. A major problem with most of these training center based RCSCs is that they are not located geographically in areas that are most easily accessed by the majority of those in need of the services.

In FY12, DBHDS, along with stakeholders, will begin to study, the options for transition of the RCSCs to the community. Questions that must be explored include what services should be offered at each RCSC, what funding is required to provide those services, how can medical professionals currently employed at training centers transition to community-based RCSCs, who will operate the RCSCs (state, CSBs, or private providers) in each region, and where will they be offered. DBHDS will report the results of this study next year clarifying whether or not additional funding or legislation will be required to make the transition.