REPORT OF THE INDEPENDENT REVIEWER

ON COMPLIANCE

WITH THE

SETTLEMENT AGREEMENT

UNITED STATES v. COMMONWEALTH OF VIRGINIA

United States District Court for
Eastern District of Virginia

Civil Action No. 3:12 CV 059

April 1, 2021 – September 30, 2021

Respectfully Submitted By

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I. EXECUTIVE SUMMARY

This is the Independent Reviewer's nineteenth Report on the status of compliance with the Provisions of the Settlement Agreement (Agreement) between the Parties to the Agreement: the Commonwealth of Virginia (the Commonwealth) and the United States, represented by the Department of Justice (DOJ). This Report documents and discusses the Commonwealth's efforts and the status of its progress during the Nineteenth Review Period, April 1, 2021 – September 30, 2021.

Throughout this Period, COVID-19 continued to impact the lives of thousands of Virginians with IDD, as well as their caregivers and service providers. The Commonwealth devoted a significant amount of attention and resources to reducing the pandemic's negative repercussions; it deserves commendation for simultaneously continuing its efforts toward achieving the Agreement's requirements.

With vaccines more readily available, and a resulting decline in the number of severe COVID-19 cases, Virginia was able to ease some of its tighter precautions at the beginning of this Period. This allowed DBHDS's oversight mechanisms to substantially renew face-to-face and onsite assessments, although stakeholders who continued to have concerns advocated for maintaining telehealth visits.

The Commonwealth's continued efforts led to notable improvements and the achievement of many Compliance Indicators. Highlights of these accomplishments include:

- With the resumption of onsite observations and interviews, DBHDS's Office of Licensing (OL) completed its assessments of the adequacy of provider supports and services, and therefore met the applicable Indicator for the first time as well as meeting six other Indicators.
- Together with OL's Special Investigations Unit, the Mortality Review Committee (MRC) implemented new and refined processes, expanded its information gathering efforts, improved its determinations of potentially preventable deaths, and reduced the number of deaths categorized from an unknown cause. The MRC met four Indicators for the first time.
- DBHDS assigned additional staff to provide guidance and intensified its efforts resulting in the Regional Support Teams meeting ten Indicators for the first time.

- DBHDS finalized and distributed its *Practice Guidelines* and its *Behavior Support Plan Adherence Review Instrument* (BSPARI). This represented a significant milestone. For the first time, the *Practice Guidelines* established a sound basis for behavioral programming standards, and BSPARI became the Department's first monitoring tool to determine the extent to which providers adhere to these standards.

Despite these successes and other ongoing important work, long-standing and unresolved obstacles continued to compromise Virginia's progress toward achieving compliance with the remaining Provisions.

Once again, the most impactful among these obstacles was the lack of reliable and valid data for compliance reporting. Although DBHDS continued to place significant focus on this issue, the functionality of the Commonwealth's quality and risk management system continued to be severely hampered. Virginia's ability to effectively identify and implement needed improvements to its service systems will remain compromised until DBHDS can determine that its sources provide data that are both valid and reliable.

Reliable and valid data are the fuel for any effective quality and risk management system. In addition to this fuel, components of a workable system must include performance standards, monitoring tools that can assess adherence to these standards, and qualified reviewers who can properly determine when standards are met or unmet.

Some evaluation tools require clinical qualifications and expertise. For example, the Individual Services Review (ISR), conducted during this Period by qualified clinicians, identified significant service inadequacies for individuals with intense behavioral needs. This was in sharp contrast to the evaluation conducted by DBHDS's Quality Service Reviews (QSR) vendor's non-clinical auditors, who found, for nearly all of these same individuals, that their needs were met. The inadequacies found by the ISR's clinical reviewers provide important and substantial information for the development of the Commonwealth's much needed and targeted Quality Improvement (QI) initiatives. In comparison, the QSR non-clinical auditors' findings did not identify any strong need for system-wide QI initiatives.

Even though the ISR study identified clear discrepancies with the QSR findings, the comparison did not establish whether the basis for the discrepancies was due to the QSR's inadequate standards or tools, or due to the reviewers' inadequate training and qualifications.

The status of services in 2020 for individuals with intense behavioral needs was prior to Virginia establishing standards for such services in 2021 in the *Practice Guidelines*. Completing the ISR/QSR discrepancy study has now established a baseline for the quality of behavioral services prior to the new service standards coming into effect. Regardless, the study comparison did clarify that DBHDS's QSR process was inadequate and needs substantial improvements.

The findings of the ISR/QSR discrepancy study again identified serious shortcomings in the availability and adequacy of Virginia's behavioral services for individuals with intense behavioral needs. Even though DBHDS now has its *Practice Guidelines* and BSPARI, all reviewers must have sufficient qualifications and training to make appropriate judgments. These judgments can then lead to accurate and sufficient conclusions that support the development of effective quality improvements. The most serious problem for any quality system is a review process that does not correctly and thoroughly identify problems and obstacles that must be addressed and resolved.

External oversight and evaluation systems that do not dependably identify significant service system problems, frequently ones that are known to exist, as well as information about their root causes, do not work. Instead, they create insidious problems for all involved, threatening the viability of the Commonwealth's entire quality and risk management system. Inadequate monitoring systems waste resources, frustrate those who provide and use the information, and squander the trust of the very stakeholders – providers, CSBs, individuals and family care givers – whose support is needed to effectively implement quality improvement initiatives.

Although Virginia planned and implemented additional initiatives, by the end of this Review Period the Commonwealth had still not responded sufficiently to resolving several known and persistent obstacles that are critical to achieving the remaining Provisions of the Agreement. Examples include:

- As referenced above, DBHDS has not determined that its information sources provide reliable and valid data for compliance reporting;
- Virginia does not have a sufficient number of qualified behavioral specialists and experienced residential and day service providers with available capacity to meet the service needs of individuals with significant behavioral challenges;
- Providers are not reporting information from their quality improvement programs;
- The DMAS transportation process does not include a suitable method for determining reliable non-emergency medical transportation; and

- DMAS still uses an inadequate provider training monitoring process.

Subsequent to the Nineteenth Review Period, the Commonwealth agreed to curative actions to address and fulfill its obligations related to several of the Compliance Indicators that it has not yet met: these actions were jointly filed by the Parties with the Court in October and November 2021. Negotiating and agreeing to these curative actions reflects Virginia's continued efforts to achieve compliance with the Settlement Agreement's Provisions and their Compliance Indicators.

Following this Period's studies of the status of 23 Provisions and 166 of their associated Compliance Indicators, the Independent Reviewer determined that Virginia has met 100 of these 166 Indicators (60%), compared with meeting 52 of these Indicators (31%) during the Seventeenth Period a year ago. Caution should be exercised in reviewing this data, however, due to the unequal value of the various Indicators.

Moving forward, the Independent Reviewer strongly recommends that the Commonwealth immediately concentrate on resolving the obstacle of the lack of reliable and valid data. This will then allow achievement of many of the remaining Compliance Indicators, as well as the development of an effective quality and risk management system.

II. DISCUSSION OF COMPLIANCE FINDINGS

A. Methodology

For this Nineteenth Review Period, the Independent Reviewer prioritized the following areas in order to monitor the Commonwealth's compliance with the requirements of the Agreement:

- Quality and Risk Management;
- Behavioral Programming;
- Provider Training;
- Quality Improvement Programs;
- Integrated Day Activities and Supported Employment;
- Transportation;
- Regional Support Teams;
- Mortality Review;
- Office of Licensing/Office of Human Rights;
- Regional Quality Councils; and
- Public Reporting.

To analyze and assess Virginia's performance across these areas and their associated Compliance Indicators, the Independent Reviewer retained eleven consultants to assist in:

- Reviewing data and documentation produced by the Commonwealth in response to requests by the Independent Reviewer, his consultants and the Department of Justice;
- Discussing progress and challenges during regularly scheduled Parties' meetings and in work sessions with Virginia officials;
- Examining and evaluating documentation of supports provided to individuals;
- Interviewing caregivers, provider staff, and stakeholders;
- Verifying the Commonwealth's determinations that its data sources provide reliable and valid data that are available for compliance reporting; and
- Determining the extent to which Virginia maintains documentation that demonstrates it meets all Compliance Indicators and achieves Compliance with the Provisions.

The Independent Reviewer focused all Nineteenth Period studies on:

- The respective Provisions that the Commonwealth had not yet achieved and their associated Compliance Indicators, and
- Whether Virginia had maintained Sustained Compliance for the Provisions that it had achieved previously.

To ensure that the Independent Reviewer had the facts necessary to determine whether the Commonwealth had met the metrics of the Indicators and achieved Compliance, Virginia was asked to provide sufficient documentation that would:

- "Prove its Case" for having achieved all Indicators for the Provisions being studied, and
- Provide its assessments and findings that its data sources for the Provisions being studied provide reliable and valid data for compliance reporting.

To determine any ratings of Compliance for the Nineteenth Review Period, the Independent Reviewer considered information provided by the Commonwealth prior to October 15, 2021, and responses to consultant requests for clarifying information up to November 1, 2021. To determine whether Virginia had met the Compliance Indicators and achieved the Provisions studied, the Independent Reviewer considered the findings and conclusions from the consultants' studies, the Commonwealth's planning and progress reports and documents, as well as other sources.

The Independent Reviewer's determinations that Compliance Indicators have or have not been met, and the extent to which Virginia has achieved Compliance, are best understood by reviewing the Discussion of Compliance Findings and the consultants' reports, which are included in the Appendices. To protect individuals' private health information, the summaries from the studies of individuals' services included in the respective consultant reports are provided to the Parties under seal.

For each study, the Commonwealth was asked to provide its records that document the proper implementation of the Provisions and the associated Compliance Indicators being reviewed. Information that was not provided for the studies was not considered in the consultants' reports or in the Independent Reviewer's findings and conclusions. If Virginia did not provide sufficient documentation, the Independent Reviewer determined that it had not demonstrated meeting the associated Compliance Indicator(s).

Since DBHDS has not yet found that its sources provide reliable and valid data for compliance reporting, the Independent Reviewer's ratings of "met*" are not yet final and cannot be used for Compliance determinations, but rather are for illustrative purposes only.

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

B. Discussion of Compliance Findings

1. Quality and Risk Management

Background

Section V of the Agreement requires the Commonwealth to develop and implement a Quality and Risk Management (QRM) System, "to ensure that all services for individuals receiving services … are of good quality, meet individual's needs, … and … to ensure that appropriate services are available and accessible for individuals in the target population … "

Reliable and valid data are the sole, essential fuel for the effective operation of any QRM system, especially one that seeks to ensure that the services provided to individuals with IDD "are of good quality." In the Agreement, Virginia committed that it would begin to collect and analyze reliable data by June 30, 2014. Ever since then, however, the Independent Reviewer has consistently reported problems with the reliability of the Commonwealth's data.

During the Thirteenth Review Period, in the fall of 2018, the Independent Reviewer identified significant concerns with the adequacy of DBHDS's QRM system's framework (i.e., its structure and operations), and urged Virginia to create a comprehensive data quality improvement plan with specific steps and milestones. Its purpose was to expand and improve the quantity and quality of data to measure performance and to provide a structure for greater accountability.

A year later, at the time of the Fifteenth Period review in 2019, the consultant's study documented that DBHDS's Office of Data Quality and Visualization (Office of DQV) had implemented a multi-phase initiative that delved deeply into the basis of data reliability and validity across multiple source systems. Their *Data Quality Monitoring Plan* indicated the Department's intent to complete a multi-phase structural assessment of twelve such systems. Overall, these source system assessments

conducted in late 2019 and early 2020 were thorough and objective; and they found data reliability concerns across the board.

At the same time, in the fall of 2019, the Independent Reviewer reported that the functionality of the Commonwealth's QRM framework was severely hampered by the lack of valid and reliable data across much of the service system.

Studies conducted over the previous few years had consistently found that problems with data reliability and validity had negatively impacted the ability of DBHDS to complete meaningful analyses of the various data collected, so much so that needed improvements could not be effectively identified and implemented. In recognition of the inherent flaws in their data source systems, DBHDS had developed various "work-arounds" (i.e., manual processes) to enhance the reliability of the data these systems produced. However, many of those work-around processes were not documented and were, therefore, subject to interpretation, variations and human error. Without documented data provenance, DBHDS was not able to demonstrate that data were reliable.

For the Seventeenth Period review in the fall of 2020, the Independent Reviewer again requested that DBHDS provide documentation that showed its Office of DQV had completed the required annual reliability and validity assessments of its data sources, and had determined that these source systems provided reliable and valid data for compliance reporting. DBHDS responded that the annual assessments would not take place until June 2021.

The Seventeenth Period study found that DBHDS's documentation acknowledged that its data reliability problems had continued, and that problems previously identified by its assessments had not been remedied. To provide reliable data, the Department determined that it was essential to prioritize recommendations from the *Data Quality Monitoring Plan* and to align these results with their Information Technology (IT) department's strategic plans. Until that occurred, DBHDS's data source systems would likely continue to produce unreliable data for compliance reporting. This was an important finding, especially in light of the Parties' Compliance Indicator agreement in early 2020 that Virginia's data sources would be used for compliance reporting only after DBHDS found that its data sources produced reliable and valid data.

Despite these ongoing data reliability and validity issues, during the Seventeenth Review Period DBHDS maintained a serious and concerted management focus that allowed the Department to achieve 12 of the 50 QRM Compliance Indicators for the first time.

Regarding Provision V.C.4.'s nine Indicators, the Commonwealth achieved six Indicators 32.01, 32.02, 32.05, 32.06, 32.08 and 32.09; it did not meet three Indicators 32.03, 32.04 and 32.07.

Regarding Provision V.D.1.'s eight Indicators, Virginia achieved five Indicators 35.01–35.04 and 35.06; it did not meet three Indicators 35.05, 35.07 and 35.08.

Regarding Provision V.D.2.a.-d.'s eight Indicators, the Commonwealth met 36.01 and did not meet Indicators 36.02–36.08.

Regarding Provision V.D.3.'s 24 Indicators, Virginia achieved one Indicator 37.03; it did not meet 21 Indicators 37.04–37.24. The Independent Reviewer was not able to determine whether the Commonwealth achieved the remaining two Indicators 37.01 and 37.02.

Regarding Provision V.D.4., Virginia did not meet the single Indicator 38.01.

Nineteenth Period Study

For the latest study, the Independent Reviewer retained the same independent consultant to assess the status of Virginia's QRM System. DBHDS was asked to provide the necessary documentation and arrange interviews for the review. There was, however, a significant and unfortunate delay in the Department's production of the requested documents and in the arrangement of interviews.

As a result, some aspects of the proposed study methodology (e.g., interviews with a sample of providers, CSBs and Regional Council members) could not be completed as originally planned. As well, the review of DBHDS's Quality Service Reviews (QSR) process had not been fully completed and was postponed until a future review period. In addition, many documents were not provided in time for the consultant to complete any independent verification of their content.

For this Nineteenth Period Review, despite the delay, the consultant determined that the Commonwealth did make some progress toward meeting the Compliance Indicators associated with the QRM System Provisions that were not previously achieved. DBHDS collected considerable data from various sources and took steps to improve data quality, such as defining some data provenance and data manual processes.

However, based on interviews and reviews of the Department's documentation, DBHDS had not sufficiently addressed the findings and recommendations of its own assessments. Although the

Department had taken some steps to improve data quality in eight of the twelve previously-studied source systems, it had not fulfilled the associated Indicator requirements to remedy the substantive reliability and validity problems, complete assessments that verified that the data provided were now reliable and valid, or make the required determinations that any of its source systems produced valid and reliable data for compliance reporting.

During this Period, Virginia's lack of reliable and valid data continued as an overarching theme that negatively impacted DBHDS's ability to recommend, develop and implement required quality improvement initiatives, and also to fulfill its own commitment to Continuous Quality Improvement, as described in the Department's *Quality Management Plan.*

It is important to note that in June 2021, DBHDS produced its *Data Quality Monitoring Plan – Reassessment and Actionable Recommendations* (Plan) to address the requirements of Provision V.D.3.'s Indicator 37.07, in accordance with Provision V.D.2.'s Indicators 36.01 and 36.05. Although the Plan appeared thorough and promising, it did not include an estimated time frame for the Department to find that its data sources provide reliable and valid data for compliance reporting. This means that the Commonwealth's data source systems will not provide reliable and valid data for compliance reporting for its performance during the next Twentieth Review Period, October 1, 2021 – March 31, 2022.

For Virginia's status related to the following QRM System Provisions, the consultant's report highlighted the following:

<u>Provision V.C.4.</u>
This Period's review examined the progress DBHDS had made in offering training and guidance to providers on proactively identifying risks of harm, conducting root cause analyses and developing and monitoring corrective actions. The Department continued a positive trend of expanding on the availability of, and updates to, the training and guidance to providers on these topics.

Compliance Indicator 32.07 requires that DBHDS use data and information from risk management activities to identify topics for future content; make determinations as to when existing content needs to be revised; and identify providers that are in need of additional technical assistance or other corrective action. But, as described above, since DBHDS had not found its data sources to be valid and reliable, they cannot be used for compliance reporting. In addition, the

Department did not provide sufficient evidence to show that it had required providers previously found to be non-compliant with risk management requirements to complete the requisite training.

Provision V.D.1.

This study considered the extent to which DBHDS operated its HCBS Waivers in accordance with the Center for Medicaid and Medicare Services (CMS) approved Waiver quality improvement plan, including the review of Waiver performance measures in six domains (i.e., the Waiver Assurances.). The review found that the CMS-approved Waiver quality improvement plan included content that addressed all of the required criteria, that DMAS and DBHDS had developed Waiver performance measures that were posted on the CMS and DBHDS websites, and that the Quality Review Team (QRT) reviewed these performance measures quarterly. However, once again the lack of valid and reliable data hampered the ability of the QRT to make accurate analyses, and the QRT minutes continued to show that the Team often failed to focus on systemic remediation. The QRT issued an end-of-year report, but it was not available in time for this study.

V.D.2.a.-d.

This review studied the progress DBHDS had made toward its ability to collect and analyze reliable and valid data with regard to availability, accessibility and quality of services to people in the target population, and the progress the Department had made in the development and implementation of performance measures and associated surveillance data. As described above, DBHDS issued updates to its *Data Quality Monitoring Plan*, but had not completed an annual (i.e., within 365 days of the previous) review of its data source systems.

In addition, the Office of DQV had not consistently completed a review of the data collection methodologies that DBHDS used to collect Performance Measure Indicator (PMI) data. Many PMIs had not been reviewed in the past 12 months or following modifications to the data collection methodology, and some had not been reviewed at all. Overall, the lack of valid and reliable data yet again negatively impacted the Commonwealth's ability to meet some of this Provision's Indicators.

V.D.3.

This study reviewed the progress DBHDS had made toward the development of specific measures in the eight domains specified in this Provision (i.e., safety and freedom from harm; physical, mental, and behavioral health and wellbeing; avoiding crises; stability; choice and self-

determination; community inclusion; access to services; and, provider capacity). It also examined the Key Performance Areas (KPAs) and related data collection methodologies and sources.

DBHDS had established quality committees and workgroups and had designated each with specific responsibilities for developing and monitoring measures and collecting surveillance data in each of the eight domains. However, although the surveillance data to be collected were finalized, the KPA work groups had not identified the data to be reviewed or where to obtain the data. Overall, the implementation of the monitoring and measuring responsibilities continued to be negatively impacted by the lack of valid and reliable data.

V.D.4.

This review examined the progress DBHDS had made in the collection and analyses of data from a set of prescribed sources. The single Indicator for this Provision requires Virginia to collect and analyze data from 13 source systems, at a minimum. At the time of this study, the Department continued to collect data from all of the designated sources, as required. While the *Data Quality Monitoring Plan Source System Annual Update,* dated April 2021, outlined some steps taken to improve data quality in eight of the previously-studied source systems, DBHDS did not assert that any of the source systems produced valid and reliable data. Due to the Department's significant delay in providing documents for review, this study could not complete any independent examination of the implementation of the improvements listed and could not validate the assertions or the extent to which any of them might have sufficiently ameliorated the previously-identified concerns and deficiencies.

See the consultant's full report in Appendix H.

Conclusion

The Nineteenth Period study concluded that the Commonwealth has met* 29 of the 50 Compliance Indicators for Provisions V.C.4., V.D.1., V.D.2.a.-d., V.D.3. and V.D.4., compared with having met just 12 of these Indicators during the Seventeenth Period's review.

Regarding Provision V.C.4.'s nine Indicators, Virginia has again met six Indicators 32.01, 32.02, 32.05, 32.06, 32.08 and 32.09, but has not achieved three Indicators 32.03, 32.04, and 32.07. Therefore, the Commonwealth remains in Non-Compliance with this Provision.

Regarding Provision V.D.1.'s eight Indicators, Virginia has met just two Indicators 35.02 and 35.04, but has not achieved six Indicators 35.01, 35.03, 35.05–35.08. Therefore, the Commonwealth remains in Non-Compliance with this Provision.

Regarding Provision V.D.2.a.-d.'s eight Indicators, Virginia has met just two Indicators 36.02* and 36.07*, but has not achieved six Indicators 36.01, 36.03 – 36.06, and 36.08. Therefore, the Commonwealth remains in Non-Compliance with this Provision.

Regarding Provision V.D.3.'s 24 Indicators, Virginia has met 19 Indicators 37.01*, 37.03, 37.04, 37.08 – 37.10*, 37.11, 37.12*, 37.13, 37.14*, 37.15, 37.16*, 37.18*, 37.19, 37.20*, 37.21, 37.22*, 37.23 and 37.24*., but has not achieved 5 Indicators 37.02, 37.05, 37.06, 37.07, 37.17, Therefore, the Commonwealth remains in Non-Compliance with this Provision.

Regarding Provision V.D.4., Virginia has not achieved Compliance Indicator 38.01. Therefore, the Commonwealth remains in Non-Compliance with this Provision.

**Note*: Since DBHDS has not yet found that its sources provide reliable and valid data for compliance reporting, ratings of "met*" are not yet final and cannot be used for Compliance determinations, but rather are for illustrative purposes only.

2. Behavioral Services

Background

The importance of the Commonwealth's service system in meeting the needs of individuals with complex behavioral and/or medical needs is highlighted throughout the Agreement. To comply with its obligations, Virginia agreed to develop and implement several quality review processes to ensure that its programs are of good quality, protect people with IDD from harm and are appropriately meeting the needs of the individuals served.

One of these processes is the annual Quality Service Reviews (QSR), which is required to collect information from face-to-face interviews, face-to-face assessments, and on-site direct observations of the individual's program settings. The QSR reviewers determine whether providers have identified and met the individual's needs, including behavioral and/or medical support needs. In addition, the information collected from the QSRs is to be used to improve practice and the quality of services on the provider, CSB, and system-wide levels.

For each of his Reports to the Court, the Independent Reviewer has examined either the behavioral or medical supports provided to a cohort of individuals with IDD. To conduct these examinations, he developed, together with an independent consultant, an Individual Services Review (ISR) methodology and Monitoring Questionnaire. Each of the cohorts for these ISR studies was selected to provide information regarding the extent to which the Commonwealth's community-based service system identified and met the support requirements of individuals with complex medical or behavioral needs.

The Seventeenth Period ISR study in 2020 focused on individuals with complex behavioral needs. This review was initially designed to determine whether Virginia's QSR process was sufficient to identify whether the needs of individuals with intense behaviors were met and whether providers kept these service recipients safe from harm. However, a complete round of DBHDS's revised QSR process had not been completed, and the facts needed to make this judgment were not available for analysis. So the scope of the study was narrowed accordingly.

Overall, the consultants' findings from the 2020 ISR study were comparable to those from previous reviews. It documented that the Commonwealth's community-based service system lacked standards for what constitutes both an adequate behavior program and appropriate implementation. The 2020 ISR study also concluded that Virginia's service system lacked a sufficient number of behavioral specialists, as well as residential and day activities service providers, all with the requisite level of experience, expertise and available capacity. Furthermore, it determined that most of the Commonwealth's current behavioral programming did not meet generally accepted standards and practice recommendations. Finally, if Virginia's community-based system was to meet the behavioral support needs of individuals with IDD receiving Waiver-funded services, the ISR study strongly recommended that action be taken to address and resolve both the limited access to behavioral services and the failure to meet the minimum elements required for adequate behavioral programming.

Nineteenth Period Study

Since the 2020 Seventeenth Period study, the Commonwealth took some steps to address the findings of inadequate behavioral programming. For example, Virginia incorporated standards for an adequate behavioral support plan into its permanent DD Waiver regulations, and produced the *Practice Guidelines* that defined the minimum elements that constitute an adequately designed behavioral program. These actions resulted in the Commonwealth meeting two of Provision

III.C.6.a.i-iii.'s Compliance Indicators, namely 7.15 and 7.17. Additionally, DBHDS issued *Case Management Training* after the Waiver regulations became effective on March 31, 2021.

For the Nineteenth Review Period study, the same lead consultant was retained, together with three other Board Certified Behavior Analysts (BCBAs), to assess Virginia's performance regarding its obligations related to behavioral programming for individuals with IDD.

This ISR study was designed to specifically examine two of the Compliance Indicators under Provisions V.I.1. and V.I.2., namely 51.05 and 52.01 respectively. These require QSRs to assess, on both a system-wide level and on an individual service-recipient level, whether providers are keeping individuals safe from harm and are providing access to treatment, and whether individuals' needs are identified and met.

In addition, the purpose of this Period's review was to identify whether there were discrepancies between the QSR vendor's non-clinical auditors who had completed the 2020 QSR study, and the determinations of the four clinically qualified ISR reviewers, all with extensive experience in the provision of behavioral services to individuals with significant challenging behaviors in community-based settings. The study again utilized the Independent Reviewer's *Individual Services Review Monitoring Questionnaire* to determine whether the selected individuals' needs for behavioral services were met. To gather additional information about the status of behavioral programming in 2020, the study also used the minimum elements for behavioral services that involve the use of a Behavior Support Plan (BSP), as detailed in DBHDS's *Practice Guidelines.*

The ISR study's findings were based on the reviews of a randomly selected sample of 40 individuals who were evaluated during the 2020 QSR study, and whose Service Eligibility Assessment scores were Level 7, the level for individuals with intense behavioral needs. These ISR reviews included interviews with residential providers and, in some instances, behavioral specialists, as well as the examination of numerous documents regarding the individual, including, when available, BSPs, Functional Behavioral Assessments (FBAs), and Individual Support Plans (ISPs).

At the onset, the Independent Reviewer and his consultants randomly selected the names of the 40 individuals from a DBHDS list of those who were purported to have been evaluated during the Department's 2020 QSR study. However, as the review unfolded, it became clear that information about nine of the individuals had not been included in the findings from the QSR study under examination.

Further, it should be noted that the provided documentation utilized by the ISR reviewers may have been considerably different from the documents available to and reviewed by the QSR auditors.

Following are key points of the ISR study's findings:

- Of the 31 individuals reviewed, the ISR clinical reviewers found that seven (22.6%) were not protected from harm and could not access necessary treatment. The QSR auditors, in comparison, identified only one (3.23%) of these seven individuals.
- The ISR reviewers identified 28 individuals (90.3%) who did not have their needs identified and met, including those related to health and safety. The QSR auditors had identified only one of these 28 individuals (3.6%).
- The ISR reviewers found that a substantial percentage of individuals in the sample who needed access to behavioral programming were not receiving it. Of the 23 individuals without BSPs in place and implemented, the ISPs for ten of these individuals (43%) had documented that a BSP was needed.
- Most of the behavioral programming provided in 2020 to the individuals in the sample did not meet the minimum service standards prescribed in 2021 by DBHDS's *Practice Guidelines*.

These findings indicate the baseline status of behavioral services prior to DBHDS's introduction of minimum standards and the substantial improvements needed to meet these standards in the future. Improving access to available behavioral services that meet minimum quality standards is critically important for many individuals in the target population, especially those with Supports Intensity Scale (SIS) Level 7 needs and Waiver-funded services. The majority of the individuals reviewed in the ISR study had demonstrated unsafe behavior that placed themselves and others at risk, and negatively impacted their quality of life, ability to learn or to generalize already learned skills and achieve greater independence.

The ISR study findings identified two issues that require the Commonwealth's further attention and review:

- The level of need for behavioral services and support was determined by the clinically trained ISR reviewers to be much higher than documented in the individuals' ISPs. During the early years of the Settlement Agreement, the ISR studies found that ISPs, especially for individuals with complex needs, did not recommend referrals for crisis services, integrated day activities, supported employment, independent housing, or integrated residential

service options. However, once Virginia developed and improved the availability and quality of such services, they were more frequently included in individuals' ISPs. It is the considered opinion of the Independent Reviewer that the lack of available quality services is a significant factor for these services not being included in individuals' ISPs.

- The case managers' on-site visit tools were not adequately or correctly completed for a number of individuals. For example, for individual #24, the on-site visit tool indicated that all services were implemented appropriately, even though the FBA was over two years out of date and written for a previous placement. The case manager who completed this on-site tool also answered "Not Applicable" to the question of whether behavioral supports were available and occurring as authorized.

See Appendix A for the consultants' full description and analysis of the ISR study's findings.

Conclusion

Regarding Provision III.C.6.a.i-iii., the Commonwealth met Compliance Indicators 7.15 and 7.17.

Regarding Provision V.I.1., Virginia did not achieve Compliance Indicator 51.05, so therefore remains in Non-Compliance.

Regarding Provision V.I.2., the Commonwealth did not meet Compliance Indicator 52.01, so therefore remains in Non-Compliance.

3. Provider Training

Background

The Provider Training Provisions V.H.1. and V.H.2. have 16 associated Compliance Indicators that focus on the training and supervision of all staff providing services to the individuals at the heart of the Settlement Agreement.

The detailed requirements of these Indicators (49.01–49.13 and 50.01–50.03) emphasize the importance of specific mandated core competencies for all staff. For example, Direct Support Professionals (DSPs) and their supervisors must demonstrate the knowledge and skills to provide supports that meet individuals' needs, whether these competencies involve providing positive behavioral supports or effective communication, or identifying potential health and safety risks or opportunities for community integration and social inclusion. To ensure that services under the

Agreement meet the needs of the individuals with DD Waiver-funded services, the Indicators require that DSPs and supervisory staff in the DD system successfully complete training, testing and demonstration of the competencies specific to health and safety.

These competencies include Values that Support Life in the Community, Introduction to Developmental Disabilities, Waivers for People with Developmental Disabilities, Communication, and Health and Safety. A description of the competencies and related training materials for each are available to all DSP and supervisory staff through the Virginia Commonwealth University training site. This site also contains links to the *DSP and DSP Supervisor DD Waiver Orientation and Competencies Protocol*, the *Basic Competencies Checklist*, and *Advanced Competencies Checklists*.

During the Seventeenth Review Period in 2020, the Independent Reviewer's consultant examined numerous documents that were provided by the Commonwealth to prove it had properly implemented the Provider Training Provisions. These included previous DD Waiver and Office of Licensing (OL) regulations, and recent data submitted by DMAS and DBHDS from their respective provider monitoring processes. The consultant found evidence of considerable effort to ensure that provider staff were trained in the knowledge and performance competencies required for the exercise of their job responsibilities.

The Seventeenth Period study concluded that for Provision V.H.1., the Commonwealth met Indicators 49.01, 49.05 – 49.09, and 49.13. However, Virginia had not met the requirements for Indicators 49.02 – 49.04 and 49.10 – 49.12.

Regarding Provision V.H.2., Virginia met the three associated Indicators 50.01, 50.02 and 50.03, and therefore commendably achieved Compliance with this Provision for the first time.

Nineteenth Period Study

During this Review Period, the same consultant was retained to assess the Commonwealth's performance regarding its obligations related to Provider Training.

The consultant's review, which included onsite visits, documented that Virginia continued to make significant progress in its efforts to develop and implement a statewide competency-based core training curriculum, and to structure and conduct thorough and reliable regulatory oversight of providers' implementation of this curriculum. The Commonwealth developed, refined and delivered useful and effective training curricula to ensure that provider staff can be trained in the

required knowledge and performance competencies, including protecting the health, safety, and wellbeing of the individuals with IDD reliant on their support.

Although DMAS and DBHDS continued to conduct oversight to ensure that providers were fully implementing the competency-based training requirements for DSPs and their supervisors, the restrictions imposed by the pandemic impacted the methods employed by both Departments. Although DBHDS's OL resumed onsite inspections in April 2021, DMAS had discontinued onsite Quality Management Reviews (QMRs) in mid-March 2020, and continued to use only remote reviews. The remote inspection processes significantly limited the thoroughness of licensing inspections as it precluded onsite interviews and the direct observations that result from this to verify staff competencies. The DMAS QMR record review process does not include these activities to verify that staff can demonstrate staff competencies.

In time for the beginning of this Review Period, the new DMAS provider training regulations were finalized and became effective on March 31, 2021. The DMAS QMR process, however, did not use the new regulations as its basis for determination of regulatory compliance for any time during this Period.

DMAS decided to incorporate the requirements of these new regulations into its QMR process and to implement the new regulations in its reviews sometime after October 1, 2021. DMAS reported that its Health Care Compliance Specialists are to begin conducting the revised QMR reviews during the first months of the Twentieth Review Period.

At the time of this study, DMAS had not projected a date for completing its detailed set of instructions that will guide its revised QMR process. Since the consultant was not given even a draft of these new instructions, they could not be reviewed or their sufficiency verified, especially regarding the inadequacies already identified both in the soon-to-be-phased-out QMR process and with its sampling methodology.

Given the delay in the use of the new provider training regulations, the Commonwealth is unlikely to have performance data produced by the revised process until June 2022 at the earliest. Meanwhile, Virginia is yet to decide on a large enough sampling size that will be sufficient to allow findings to be generalized to all DSPs and their supervisors. Once the sampling size is determined, and the new and adequate QMR process is effectively implemented and completed, the Commonwealth's monitoring process can then assess the extent to which the requirements for Indicator 49.04 have been met.

The current QMR process was found to be inadequate both in evaluating and generalizing its findings regarding whether all "DSPs/Supervisors, including contracted staff" met the training and core-competency requirements specified in Indicator 49.02.

The QMR use of provider documentation as the sole basis to verify that the providers' services met all Waiver requirements was insufficient for determining Virginia's achievement of Indicators 49.02 and 49.03. For example, the QMR process did not include a review of the providers' relevant policies that require their staff to complete competency-based training, nor of the providers' procedures that detail how such training is delivered. In addition, the process does not review any provider documentation at all related to Indicator 49.03. This Indicator states that staff who have not passed "a knowledge-based test...are accompanied and overseen by other qualified staff…" The QMR process also does not include interviews with DSPs or their supervisors to verify information documented on the providers' Competency Checklist.

Regarding the sampling methodology, DMAS reported that, of the hundreds of service provider agencies in Virginia with thousands of DSPs and their supervisors providing Waiver-funded services, the Department conducted and completed QMRs of only 29 providers over nine months, i.e., from October 1, 2020 – June 30, 2021. DMAS did not provide its sampling calculations or its confidence level that the QMR findings from these reviews can be generalized to the cohort.

For this Nineteenth Period review, DBHDS provided a final *Office of Licensing Guidance for a Quality Improvement Program* to describe how they ensured implementation of the final regulations (*12VAC35-105-620*). However, the Department did not provide evidence to show that its licensed providers, including CSBs, had completed any needed corrective action to address quality improvement plan deficiencies.

DBHDS's OL continued to refine its inspection procedures related to its long-standing regulations addressing the provision of competency-based training for DSPs and their supervisors. The Department continued to deliver extensive training related to the new regulations. As a result, this study found that provider policies as well as interviews with provider staff reflected a consistent level of knowledge about relevant DBHDS licensing requirements. Furthermore, OL continued to refine its guidance document, the *Annual Checklist Compliance Determination Chart – FY 2021*, which it utilized to train Licensing Specialists and as a reference tool while conducting annual inspections. For this Period's study, the documents reviewed, the onsite interviews with provider staff and those with DBHDS Licensing Specialists confirmed that the licensing inspection procedures addressed

in Indicators 49.08–49.12 were thorough, and that the Licensing Specialists interviewed demonstrated substantial detailed knowledge of the regulations and the requirements for evaluating provider adherence to these regulations.

The results from the QMRs conducted by DMAS, including identified trends and patterns, are consistently presented at the Quarterly Provider Roundtable meetings required by Indicator 49.13. Providers expressed their appreciation for these meetings and recommended that they be held every two months, given the significant amount of useful information. Providers also acknowledged the expanded training, online resources, consultation, and technical assistance available to clinicians, DSP supervisors and other staff through DBHDS's Offices of Provider Development and Integrated Health. These resources are consistent with the requirements of Compliance Indicators 49.05, 49.07, and 50.01–50.03.

See Appendix G for the consultant's full report.

Conclusion

The Nineteenth Period Study concluded that the Commonwealth has met 12 of the 16 Compliance Indicators for Provisions V.H.1 (49.01–49.13) and V.H.2 (50.01–50.03), compared with having met ten of these Indicators during the Seventeenth Period's review.

Regarding Provision V.H.1, Virginia has met nine Indicators 49.01, 49.05–49.11 and 49.13*****, but has not achieved four Compliance Indicators 49.02******, 49.03******, 49.04 or 49.12. Therefore, the Commonwealth remains in Non-Compliance with this Provision.

In future Review Periods, when studying Provision V.B.'s Compliance Indicator 29.02, the Independent Reviewer will determine the extent to which DBHDS's OL has monitored providers' implementation and achievements related to Indicators 49.08–49.12.

Regarding Provision V.H.2., Virginia has once again met this Provision's three Compliance Indicators 50.01– 50.03, and, therefore, has achieved Sustained Compliance.

**Note:* Since DBHDS has not yet found that its sources provide reliable and valid data for compliance reporting, ratings of "met*" are not yet final and cannot be used for Compliance determinations, but rather are for illustrative purposes only.

***Note:* Since the end of the Nineteenth Review Period, the Parties have agreed to curative actions to address the requirements of Compliance Indicators 49.02 and 49.03.

4. Quality Improvement Programs

Background

The Agreement's three Provisions for Quality Improvement Programs (i.e., V.E.1.–3.) are focused on the requirement that all providers, including Training Centers, CSBs, and other community providers, develop and implement a Quality Improvement (QI) program, including root cause analyses, that is sufficient to identify and address significant service issues.

The purpose of these QI programs is to ensure good quality services for the health, safety, personal growth and wellbeing of Virginians with IDD, since effectively implemented QI programs can ensure that problems are identified and resolved in a timely manner. The Parties had agreed to these three Provisions and their 11 Compliance Indicators to make sure that the essential elements, structure and expectations of the QI programs would be implemented, and that performance measures and reporting expectations would be established.

However, to impose such expectations on all providers, the Commonwealth needed to establish specific State regulatory requirements for all providers, and gain needed approval by the Governor, after a lengthy government process.

During the Seventeenth Review Period, in August 2020, DBHDS's Licensing Rules and Regulations were finally approved. This allowed the Department to require all its licensed service providers to develop and implement QI programs that adhered to the specifications of the three Provisions and their Indicators.

Highlights of the consultant's findings from the Seventeenth Period's study in 2020 were:

<u>Compliance Indicators for Provision V.E.1.</u>

With the approval of the new Licensing Rules and Regulations with the specific Agreement's language included, Virginia achieved requirements related to two of the associated Indicators. However, the Office of Licensing (OL) guidance document did not address all of the relevant Indicator's requirements. OL also found that the percentage of providers who adhered to the applicable regulation did not achieve the corresponding performance measure. Finally, the

Commonwealth provided documentation that it had the required policies and guidance documents in place, but these documents did not address all requirements of the associated Indicator.

Compliance Indicators for Provision V.E.2.

This Provision requires Virginia to develop performance measures that CSBs and other providers must report to DBHDS on a regular basis. The Department's implementation of its Performance Measure Indicators (PMIs) achieved some of the related Indicator requirements. However, during the Seventeenth Period DBHDS had only just begun to establish definitions of measures for risks, so was still at an early stage of this process. As well, the data collection methodology for providers' reporting had not been established for some measures, and providers' QI programs did not report data for some of the risk measures.

DBHDS's Quality Improvement Committee (QIC) monitored and reviewed PMIs on a quarterly basis, but did not meet all requirements. The QIC had promulgated procedures that would likely be effective for future essential QI activities.

Compliance Indicators for Provision V.E.3.

This Provision's Indicators require the Commonwealth to use QSR and other mechanisms to assess the adequacy of providers' QI strategies, and to provide technical assistance and other oversight to providers whose QI strategies have been determined to be inadequate. DBHDS's new QSR vendor's tools and methodologies met the Indicator requirements. However, by the end of the Seventeenth Period, the QSR vendor had not completed its first round of evaluations; therefore, the QSR data and other findings were not yet available for review to assess the adequacy of providers' QI programs.

The Seventeenth Period study concluded that for Provision V.E.1., the Commonwealth met Compliance Indicators 42.01 and 42.03*****, but did not meet 42.02, 42.04 and 42.05. For Provision V.E.2., Virginia did not meet any of its four Indicators 43.01–43.04; and for Provision V.E.3., the Commonwealth did not meet either of its two Indicators 44.01–44.02.

***** *Note*: Since DBHDS had not yet found that its sources provided reliable and valid data for compliance reporting, ratings of "met*****" were not yet final and could not be used for Compliance determinations, but rather were for illustrative purposes only.

Nineteenth Period Study

For the latest study, the Independent Reviewer retained the same consultant to review Virginia's progress toward achieving the QI Provisions and their Compliance Indicators. Highlights from this review's findings are:

Compliance Indicators for Provision V.E.1.

Regarding Indicator 42.01, the Commonwealth finalized the regulations at *12VAC35-105-620*, entitled "Monitoring and evaluating service quality." These current regulations address each of the Indicator's requirements.

Regarding Indicator 42.02, DBHDS's *Office of Licensing Guidance for a Quality Improvement Program* adequately described how the Department ensured its relatively new Licensing Rules and Regulations were to be implemented. DBHDS also provided *Guidance for Serious Incident Reporting*, which references the regulations that fulfill the Indicator requirements for review of serious injuries.

Compliance Indicators for Provision V.E.2.

This portion of the study examined DBHDS's progress toward requiring providers to report on key indicators related to some of the domains in Provision V.D.3. The Department had completed the creation of performance measures, and these measures were reviewed quarterly, as required, by DMAS and DBHDS, and approved by CMS in the requisite areas.

This Provision also requires that the information sources include providers' QI programs. However, DBHDS only collected data from the providers' reporting of critical incidents, and not QI programs. In addition, the Department had not provided documentation that its Office of DQV had completed sufficient needed assistance to ensure that providers are well-defined and actually collect what they purport to collect, nor had DBHDS found that the applicable data source systems produced valid and reliable data.

Compliance Indicators for Provision V.E.3.

DBHDS did not provide any documentation that it had offered technical assistance and other oversight, as required, to providers whose QI strategies had been determined to be inadequate. In addition, the Department did not provide performance data that it found were reliable and valid for compliance reporting.

The consultant's full study is included in Appendix H.

Conclusion

Regarding Provision V.E.1., the Commonwealth met two Compliance Indicators 42.01–42.02, but did not meet the remaining three Indicators 42.03–42.05. Therefore, Virginia remains in Non-Compliance with this Provision.

In future Review Periods, when studying Provision V.B.'s Compliance Indicator 29.02, the Independent Reviewer will determine the extent to which DBHDS's OL has monitored providers' implementation and achievements related to V.E.1.'s Indicators' performance measures.

Regarding Provision V.E.2., the Commonwealth once again did not meet any of the four Compliance Indicators 43.01**, 43.02**–43.04 and, therefore, remains in Non-Compliance with this Provision.

Regarding Provision V.E.3., Virginia also did not meet either of the two Compliance Indicators 44.01–44.02 and, therefore, remains in Non-Compliance with this Provision.

***Note:* Since the end of the Nineteenth Review Period, the Parties have agreed to curative actions to address the requirements of Compliance Indicators 49.02 and 49.03.

5. Integrated Day Activities and Supported Employment

Background

For the Seventeenth Review Period Report, the Independent Reviewer's consultants studied the Commonwealth's progress toward achieving the Compliance Indicators for Integrated Day Activities and Supported Employment for individuals with IDD.

The consultants identified Virginia's accomplishments and the positive practices underway. The Commonwealth continued to maintain Sustained Compliance with the Integrated Day Activities and Supported Employment Provisions related to planning, regional training, data collection, tenure in employment and the work of the Regional Quality Councils (RQCs). Virginia maintained its membership in the Supported Employment Leadership Network (SELN), established a state policy on Employment First, included a term in the CSB Performance Contract requiring application of this policy, and had at least one employment service coordinator to monitor implementation of Employment First practices.

The Seventeenth Period study also identified issues of concern that must be addressed in order to achieve the associated Indicators. These included that case managers were not well-educated about Community Engagement services, and there were geographic gaps in access to these services; case managers and their supervisors were not adequately trained to discuss employment with individuals and their families in a meaningful way; existing private provider capacity was insufficient to deliver integrated services where required, especially for individuals with complex needs; Integrated Day Activities and Supported Employment performance metrics were not met; and data sources were not found to be reliable and valid. Unfortunately, the efforts to meet targets to increase employment and participation in community engagement had also been stymied by the COVID-19 pandemic.

The Commonwealth maintained Sustained Compliance with Provisions III.C.7.b.i., III.C.7.b.i.A., III.C.7.b.i.B.1.a.-e., III.C.7.b.i.B.2.a.-b., III.C.7.c. and III.C.7.d. However, Virginia did not meet the requirements of any of Provision III.C.7.a.'s ten Compliance Indicators (14.01–14.10) related to employment or community engagement, so remained in Non-Compliance with that Provision.

Nineteenth Period Study

For the latest study, the Independent Reviewer retained the same consultants to again assess the status of the Commonwealth's Integrated Day Activities and Supported Employment service system for people with IDD.

This review found that Virginia was able to sustain its previous achievements of the Provisions listed above. The Commonwealth continued to struggle, however, toward achieving the requirements of all ten Compliance Indicators associated with Provision III.C.7.a.

DBHDS and the Department for Aging and Rehabilitative Services remained committed to Virginia's Employment First Initiative. This was evidenced by continued interagency collaboration on many related projects. For example, State and Waiver funding to support Individual Supported Employment and Group Supported Employment continued; the Employment First Advisory Group (E1AG) was maintained; membership of E1AG expanded to include representatives from both mental health and substance abuse populations; and new initiatives were implemented to assist individuals with these conditions to find employment.

Overall, however, the Commonwealth achieved less than in past review periods. Fewer individuals were authorized to receive the Community Engagement service. While DBHDS continued to have

a strong commitment to the Community Engagement model, its ability to implement necessary activities to promote this service was weaker during the pandemic.

The consultants' review of 100 individual cases found a lack of understanding by case managers of the purpose of this service's integration model, and of its importance and potential to help individuals with IDD to develop employment and related social skills. Much of this regression in both employment and Community Engagement can be attributed to the pandemic: for most of the year studied, individuals were unable to go to their jobs and there were fewer opportunities to engage safely in community activities.

Regarding RQCs during the period of this review, the study found they did not fulfill all their responsibilities, as described in Provisions III.C.7.c. and III.C.7.d. For example, none of the five RQCs reviewed the employment target for sustaining employment over twelve consecutive months. In addition, DBHDS documentation indicated that not all five RQCs completed a quarterly review of employment data.

Despite these findings, the decreasing trends in employment were discussed generally by the RQCs, and there was evidence of thoughtful conversations. Over recent years, the RQC meetings had become much more meaningful. DBHDS had established and maintained a process that regularly shared important program and qualitative data with the RQCs. Understandably, the pandemic required the Department to devote significant resources to address urgent concerns related to reducing COVID-19's negative impacts on individuals with IDD, their families and service providers.

Provision III.C.7.a.'s Indicators address case management training regarding Virginia's expectations for case management services related to employment and community engagement; discussion and goal setting; starting to discuss, from age 14 on, the importance of work; timely implementation of employment service authorizations; and targets for employment.

As detailed in the consultants' latest study, the Commonwealth fully met the requirements of Provision III.C.7.a.'s Compliance Indicator 14.01 a.-g. for the first time. However, the data provided by DBHDS did not demonstrate achievement of any of the remaining nine Indicators 14.02–14.10. Also, DBHDS did not verify its data sources or the validity of its methodologies for Compliance Indicators 14.02–14.07.

See the consultants' full report in Appendix B.

Conclusion

The Nineteenth Period study found that Virginia maintained Sustained Compliance with the requirements of Provisions III.C.7.b.i., III.C.7.b.i.A., III.C.7.b.i.B.1.a.-e. and III.C.7.b.i.B.2.a.-b.

In light of DBHDS's long-standing practices that led to several positive trends mentioned above, and taking into account the unforeseen impact of the pandemic, the Independent Reviewer concluded that the Commonwealth has maintained Sustained Compliance with Provisions III.C.7.c. and III.C.7.d., despite DBDHS not having fulfilled some of its related responsibilities.

Regarding Provision III.C.7.a. (which also serves to measure III.C.7.b), the Commonwealth has met the requirements of Compliance Indicator 14.01 a.-g., but has not achieved Indicators 14.02–14.10. Therefore, the Commonwealth remains in Non-Compliance with this Provision.

6. Transportation

Background

During the Seventeenth Review Period in 2020, DMAS and its Medicaid non-emergency medical transportation (NEMT) contractor continued to make progress in the area of community transportation for individuals with IDD who receive Waiver-funded services.

However, DMAS still did not utilize a valid method to determine the extent to which DD Waiver recipients were provided reliable NEMT transportation, despite the Independent Reviewer's recommendation in the Fifteenth Report to the Court, dated December 15, 2019:

> *"As soon as possible, DMAS/LogistiCare should measure on-time performance by actual on-time data, and not by the number of complaints filed."*

In his Seventeenth Report, the Independent Reviewer stated that DMAS continued to measure transportation reliability based on the same invalid method that equated "reliability" with the percentage of "complaint free" trips, despite evidence of the suppression of complaints:

> *"… the extremely low percentage of filed complaints does not accurately represent the full scale of what is a vexing transportation reliability issue. The number and percentage of "complaint free" trips is not a valid measure of transportation reliability ... the lack of a filed complaint is not a valid measure that*

reliable transportation was provided…. The DMAS plan to 'install trip encounter billing' may be a vehicle for measuring most accurately "reliable transportation."

The Independent Reviewer again recommended that:

"The Commonwealth should provide a valid data measure regarding the receipt of NEMT reliable transportation for Waiver users. DMAS should complete implementation, ensure consistent reporting and document reliable transportation using "trip encounter billing."

Regarding the provision of non-NEMT transportation (i.e., DD Waiver agency-provided transportation), the Quality Service Review (QSR) process was not completed and, therefore, did not produce results.

The Seventeenth Review Period Report concluded that Virginia had documented results of successful initiatives that met the requirements for five of the eight Compliance Indicators for Provision III.C.8.a, namely 16.01, 16.03, 16.04, 16.05, and 16.07. For reasons stated above, however, the Commonwealth failed to meet Indicators 16.02, 16.06 and 16.08, and so remained in Non-Compliance with Provision III.C.8.a.

Nineteenth Period Study

For the latest study, the Independent Reviewer retained the same consultant who has conducted the previous reviews of the Commonwealth's community transportation-related services.

While DMAS once again continued to utilize the previously-identified invalid method of determining reliable NEMT transportation (i.e., trips without a formal complaint being filed), the Department identified potential new measures that use encounter-based trip times to generate valid on-time performance data. DMAS reported that its new "on-time performance" data collection method should be fully implemented during the Twentieth Review Period. If this is the case, and if the Independent Reviewer verifies Virginia's finding that its reported data are reliable and valid, the Commonwealth will achieve the requirements of this Indicator (i.e., 16.02) in the future.

The Department's efforts in the year since the Seventeenth Period included establishing focus groups with the DD Waiver population. This latest review verified that DMAS held two focus groups, each yielding constructive transportation feedback.

Regarding non-NEMT transportation, Virginia made progress during this Nineteenth Review Period. Compliance Indicator 16.08 requires that DBHDS's QSR vendor assess and submit an annual report to the Department's Quality Improvement Committee (QIC), showing that at least 86% of those individuals reviewed report having reliable transportation. For the first half of Fiscal Year 2021, the vendor indicated that 90% of those interviewed who received agency-provided transportation reported having no problems. If this positive rate continues, is included in the QSR annual report to the QIC, and the Independent Reviewer verifies the Commonwealth's finding that its reported data are reliable and valid, Virginia will achieve the requirements of this Indicator in the future.

During this Nineteenth Period review, DMAS was found to have sustained all other transportation activities and outcomes and to have met Compliance Indicator 16.06 for the first time. This is the Indicator that requires Virginia to conduct focus groups as needed.

See the consultant's full report in Appendix C.

Conclusion

Regarding Provision III.C.8.a., the Commonwealth met six Compliance Indicators 16.01 and 16.03–16.07, but did not achieve Indicators 16.02 and 16.08. Therefore, Virginia remains in Non-Compliance with this Provision.

7. Regional Support Teams

Background

The 2020 Seventeenth Review Period study found, not for the first time, that some CSBs had avoided submitting non-emergency referrals consistent with Regional Support Teams' (RST) protocol and timeline standards. Late referrals had been a long-standing performance problem, effectively nullifying the RSTs' ability to fulfill their purpose and essential functions of identifying and resolving obstacles to providing small integrated living settings for people with IDD. These late referrals undermined the Commonwealth's ability to achieve most of the four RST Provisions and their 13 associated Compliance Indicators.

For the Seventeenth Period, Virginia reported 73%–80% statewide achievement of submitting timely RST non-emergency referrals. Despite DBHDS having provided technical assistance, training and notification efforts to case managers, and having initiated sending quarterly RST

feedback letters to CSBs, three CSBs consistently failed to meet the required 86% benchmark. DBHDS had not required Corrective Action Plans (CAPs) of CSBs, but planned to begin doing so in October 2020, at the beginning of the Eighteenth Period.

The Seventeenth Period review also found that DBHDS had expanded its development and support efforts to both create more providers and assist existing providers in offering more integrated living options. These included the Jump Start funding program; provider designations; Provider Readiness Education Program (PREP) and participation in the Charting the Life Course. The PREP is for new providers, i.e., those who are in a queue for a license or those who were licensed within the last 12 months.

In the Seventeenth Report to the Court, the Independent Reviewer determined that the Commonwealth had maintained Sustained Compliance for Provisions III.E.1.–3. However, since Virginia had not met the requirements of seven of the 13 RST Compliance Indicators (i.e., 20.02, 20.04–20.07 and 20.11–20.12), it remained in Non-Compliance with Provision III.D.6. The Independent Reviewer also reported not being able to determine the extent to which the Commonwealth had achieved the other six RST Indicators for this Provision, namely 20.01, 20.03, 20.08–20.10 and 20.13.

Nineteenth Period Study

For the latest study, the Independent Reviewer retained the same consultant to again assess the extent to which Virginia had achieved the Provisions related to RSTs. The consultant found that the Commonwealth had assigned additional staff to provide guidance and oversight across its five Regions, a signal that DBHDS had intensified its efforts to comply with the associated RST Indicators.

However, the problem of late non-emergency referrals continued. For both the Eighteenth and Nineteenth Review Periods, DBHDS reported that timeliness rates for these referrals had unfortunately decreased from 73%–80% to 59%–72%, possibly due to pandemic-related issues. Therefore, Virginia could still not achieve the 86% rate required by the applicable Indicator.

There are two reasons for these late referrals. The first is that case managers do not submit referrals in time, even though they are already aware of an individual's potential move. As previously reported, RSTs can only effectively fulfill their purpose and responsibilities when all CSBs can ensure that their case managers submit timely referrals. The second reason involves private

providers who do not notify case managers of an individual's potential move to a new location before the RST process can be completed.

DBHDS identified a third and significant systemic obstacle to RSTs not being able to fulfill their functions. Case managers submitted a non-emergency referral on time, but the individual was placed before the RST had sufficient time to complete it process. During the past pandemic year, private providers admitted or transferred individuals with IDD either without first notifying case managers or without allowing RSTs enough time to fulfill their responsibilities.

The Agreement's Provision III.D.6. requires that the Commonwealth ensure that "no individual" shall be placed in a congregate setting with five or more individuals without the placement first being reviewed by an RST. When the Parties negotiated Provision III.D.6.'s Indicator 20.02, they were aware of various obstacles, beyond emergency placements, that undermined RSTs' ability to review "all" such placements. The Parties therefore agreed that Virginia could meet this Indicator if up to 14 percent of individuals were placed in a larger congregate setting without first being reviewed by an RST. The Commonwealth has not yet achieved this agreed upon performance measure because, in large part, the three obstacles cited above have not yet been sufficiently mitigated or resolved. The impact of the pandemic on providers has contributed to Virginia's inability to achieve the 86% performance measure included in this Indicator.

If the Commonwealth is to achieve the required 86% rate of submission of timely referrals to RSTs, DBHDS will need to take more effective actions with regard to private providers. These actions must ensure that providers fulfill their responsibilities in giving case managers timely notice of the possibility of a non-emergency placement of an individual into a larger congregate residential setting. Additionally, Virginia must reduce the frequency in which providers make unilateral decisions that are not team-based and not person-centered.

DBHDS continued to provide training and technical assistance to CSBs on RST referral requirements and continued to send quarterly RST feedback letters to CSBs. The Department informed CSBs, through an annual performance letter from the Case Management Steering Committee, that a CAP is required if their RST referrals were non-compliant. Between July 1, 2020 and December 31, 2020, DBHDS required six such CAPs. These CSBs were also placed on DBHDS's Watch List for closer scrutiny regarding RST performance. While these are encouraging steps, the Commonwealth must continue to intervene, including consistently issuing CAPs whenever individual CSBs do not fulfill their responsibilities.

This Nineteenth Period Review confirmed that Virginia maintained its processes that were in place during the Seventeenth Period. The Commonwealth has invested and sustained these efforts to facilitate its shift to a person- and family-centered service system. The latest study also verified that DBHDS tracked data, conducted quarterly assurance reviews, completed data analysis, assigned Community Resource Consultants (CRCs), examined RST data to identify service system gaps, and identified individuals who chose less integrated residential settings over the past two review cycles.

The quality of RST data was an area of major emphasis and progress. DBHDS revised its RST referral form at least twice during the past two review cycles, improved CSB understanding and participation in the RST process, instituted an effective look-behind process on the usage of Waiver slots to identify individuals not properly referred and CSB/provider adherence to reporting requirements, and refined its data analysis tools to better determine gaps in the service delivery system.

In addition, DBHDS identified weaknesses in its RST data reliability, and either planned or took corrective actions that it deemed feasible for improving data integrity. DBHDS expects that its planned incorporation of the RST referral process into its Waiver Management System (WaMS) will improve future RST data reliability.

Despite this good progress, by the end of the Nineteenth Review Period, DBHDS's Office of Data Quality and Visualization had not completed an assessment of the RST data source that found reliable and valid data for compliance reporting.

See the consultant's full report in Appendix D.

Conclusion

The Nineteenth Period study concluded that Virginia had made substantial progress regarding RSTs. For the four related Provisions, this review confirmed that the Commonwealth had continued to fulfill the requirements for Provisions III.E.1.–3., and had achieved ten of the 13 Compliance Indicators associated with Provision III.D.6.

Regarding Provision III.D.6., Virginia has met Indicators 20.01, 20.03, 20.04*, 20.05, 20.06, 20.08*, 20.09, 20.10*, 20.11 and 20.13*; but has not achieved Compliance Indicators 20.02**, 20.07 and 20.12. Therefore, the Commonwealth remains in Non-Compliance with this Provision.

Regarding Provisions III.E.1.–3., Virginia has once again maintained Sustained Compliance.

**Note*: Since DBHDS has not yet found that its sources provide reliable and valid data for compliance reporting, ratings of "met*" are not yet final and cannot be used for Compliance determinations, but rather are for illustrative purposes only.

***Note:* Since the end of the Nineteenth Review Period, the Parties have agreed to curative actions to address the requirements of Compliance Indicator 20.02.

8. Mortality Review

Background

The Seventeenth Period study of the mortality reviews examined the Commonwealth's status in implementing quality initiatives intended to reduce the rate of deaths of individuals with IDD.

This 2020 study found that DBHDS's Mortality Review Committee (MRC) had made many and impressive advances toward fulfilling the requirements of Provision V.C.5.'s 21 Compliance Indicators 33.01–33.21.

Further progress, though, was needed. The *MRC Annual Report for Fiscal Year 2019* did not meet the timeline of publication requirement. Also, since there had been too many deaths categorized in the Report as having an unknown cause, and too few deaths categorized as potentially preventable, the Fiscal Year 2019 data were inadequate to decide on QI initiatives. And to determine the likely cause of death, the Committee had gathered too little information. Further, to identify potentially preventable deaths, the Committee had revised its definitions and interpretations of the criteria, which resulted in insufficient identification of such deaths. As a result of all these factors, the MRC had to depend on prior data to develop QI initiatives.

In order to provide a useful data set to guide future Committee recommendations and initiatives, the consultant concluded that the MRC's criteria for a potentially preventable death needed to be revised. In addition, the Independent Reviewer recommended that the Committee should intensify its efforts to collect all available information before each death was reviewed, and to use standardized categories of death. These would then help the MRC to develop QI initiatives to reduce mortality rates.

It is also important to note that during the Seventeenth Period, DBHDS had not found that the data sources used by the Committee provided reliable and valid data for compliance reporting.

The Independent Reviewer determined, in his Seventeenth Report to the Court, that Virginia had met 17 Indicators for Provision V.C.5., namely 33.01–33.08, 33.09*, 33.10, 33.12, 33.13*–33.15*, and 33.18–33.20. However, the Commonwealth had not met the remaining four Indicators 33.11, 33.16, 33.17 and 33.21, and so remained in Non-Compliance with this Provision.

Nineteenth Period Review

For the latest study, the Independent Reviewer retained the same consultant to assess the status of Virginia's planning, development and implementation of the MRC membership, process, documentation, reports, and QI initiatives and evaluation to achieve Provision V.C.5. and its associated 21 Indicators.

To determine whether 19 of these Indicators were met, the consultant directly studied the actual documents that the MRC reviewed for each death, rather than depending solely on the MRC database.

The MRC took significant steps toward fulfilling the requirements of the Indicators. With the assistance of DBHDS's Office of Licensing's Specialized Investigations Unit and new regulations allowing the Department to have access to medical records from several sources, the number of deaths with unknown causes decreased, and the number of deaths categorized as potentially preventable increased. For example, from August 1, 2020, through July 31, 2021, the MRC identified 40 potentially preventable deaths, compared with identifying only 17 such deaths in Fiscal Year 2020.

In addition, the review confirmed that the Committee tracked and monitored its recommendations until implementation was completed. The study also found that the MRC had put in place a much more thorough process that resulted in reducing the number of unreported deaths.

However, the Commonwealth did not keep up with its past completion rate of mortality reviews within the 90-day period required by Indicators 33.13 and 33.15.

Again, DBHDS had not found that the data sources used by the Committee provided reliable and valid data for compliance reporting.

See the consultant's full report in Appendix E.

Conclusion

The Nineteenth Period study concluded that Virginia has met 19 of the 21 Compliance Indicators for Provision V.C.5., compared with having met 17 of these Indicators during the previous 2020 review.

The Commonwealth has met Indicators 33.01–33.08, 33.09*–33.12, 33.14, and 33.16**–33.21, but has not achieved Indicator 33.13 and 33.15. Therefore, Virginia remains in Non-Compliance with Provision V.C.5.

**Note:* Since DBHDS has not yet found that its sources provide reliable and valid data for compliance reporting, ratings of "met*" are not yet final and cannot be used for Compliance determinations, but rather are for illustrative purposes only.

***Note:* Since the end of the Nineteenth Review Period, the Parties have agreed to curative actions to address the requirements of Compliance Indicator 33.16.

9. Office of Licensing/Office of Human Rights

Background

For the Seventeenth Review Period in 2020, the Independent Reviewer's consultant identified positive cumulative impacts of several years of DBHDS investments in its oversight systems, especially in its Office of Licensing (OL). These improvements included the development of the Regional Manager's role, the Incident Management Unit, and the Special Investigations Unit. In addition, both OL and the Office of Human Rights (OHR) had implemented incident look-behind processes, which improved DBHDS's oversight of its service system.

Prior to March 2020, DBHDS's licensure process had focused equally on the 100+ OL regulations relevant to individuals with IDD. Then, in March of that year, OL added the Adequacy of Supports (AOS) checklist to its licensure process to fulfill the requirements of Provision V.G.3. For this process to work, DBHDS prioritized 27 key and 44 reference regulations to reflect the themes of seven of the eight domains listed in Provision V.D.3. Although all 100+ regulations were still available to the Licensing Specialists as the basis for a provider's citation, these 27 key regulations were now required to determine providers' adherence. To ensure that these key regulations were

addressed, the process also included a review of licensing inspection reports by Licensing Specialists' supervisors.

Regarding the eighth domain, Stability, DBHDS had projected that data points from a source other than the Licensing Regulations would provide information about it, starting during the Eighteenth Review Period.

In his Seventeenth Report to the Court in December 2020, the Independent Reviewer determined that the Commonwealth had met three of the eight Compliance Indicators associated with Provision V.C.6. (i.e., 34.02, 34.03 and 34.07) and one of the four Indicators for Provision V.G.3. (i.e., 48.03). He also determined that Virginia had not met Indicator 37.07 for Provision V.D.3. This Indicator, which the Commonwealth is required to implement in accordance with Provision V.D.2. (Indicators 36.01 and 36.05), requires DBHDS's Office of Data Quality and Visualization to assess and determine that the relevant data source provides reliable and valid data for compliance reporting. However, despite numerous assessments being conducted, DBHDS had not yet made these required determinations for compliance reporting for V.C.6. and V.G.3.

Nineteenth Period Study

For the latest study, the Independent Reviewer retained the same consultant to again assess the extent to which OL and OHR had fulfilled the relevant Compliance Indicators. The review concluded that, overall, OL and OHR continued to operate competently. Both Offices sustained, refined and strengthened the functioning of their oversight systems that were identified in the Seventeenth Report.

By gradually reinstituting onsite inspections, beginning April 1, 2021, DBHDS was able to demonstrate that it had fulfilled the requirements of the applicable Compliance Indicators.

The consultant also found that OHR had established a very positive new initiative. This cross-tabulated the incident reports submitted through the Computerized Human Rights Information System (CHRIS) with the reports from Adult Protective Services/Child Protective Services (APS/CPS). This process is similar to the required cross-tabulation of the CHRIS incident reports for emergency hospitalization with Medicaid's medical claims data.

These cross-checking processes have resulted in increased accountability for providers who have failed to file required reports, as well as improving the accuracy of the Commonwealth's data regarding timely reporting. OL reported that it had followed up on 95% of the providers that were

required to complete Corrective Action Plans (CAPs) when cited for failing to report during the fourth quarter of Fiscal Year 2021. Documentation reviewed by the consultant showed that OL had followed up appropriately (i.e., the Office had ensured that CAPs had been implemented within the necessary 45 day and/or 90 day timeframes) and had taken action when providers failed to effectively implement corrective actions.

DBHDS also reported it had maintained timely incident reporting at a rate above the Indicator-required level of 86%. Annual timeliness rates for Fiscal Year 2021 improved to 92% prior to factoring in the late reporting found in medical claims data. DBHDS reduced this rate for timely filing to 90% after conducting an appropriate adjustment analysis.

DBHDS is currently in the second year of its licensing process that includes the AOS assessments, with OL having sustained this process through the Seventeenth, Eighteenth and Nineteenth Review Periods. The latest study found that the AOS checklist assessments continued to address seven of the eight domains listed in Provision V.D.3., and that DBHDS now receives data regarding the eighth domain, Stability, from another source (i.e., from Crisis Services).

As previously reported to the Court, OL continued to utilize its Provisional status designation as the primary negative consequence for provider agencies that did not successfully implement CAPs. The Seventeenth Period study and the Nineteenth Period review both showed that OL's use of its Provisional status for underperforming providers was at a high rate, demonstrating the Office's ongoing improvements in oversight.

See the consultant's full report in Appendix F.

Conclusion

The Nineteenth Period study concluded that Virginia has met eleven of the twelve Compliance Indicators for Provisions V.C.6. (34.01–34.08) and V.G.3 (48.01–48.04), compared with having met just four of these Indicators during the Seventeenth Period's review.

Regarding Provision V.C.6., the Commonwealth has met Indicators 34.01– 34.04* and 34.06*–34.08*, but has not achieved Compliance Indicator 34.05. Therefore, Virginia remains in Non-Compliance with this Provision.

Regarding Provision V.G.3., even though the Commonwealth has met this Provision's four Compliance Indicators 48.01 – 48.04*, Virginia remains in Non-Compliance with this Provision.

* *Note*: Since DBHDS has not yet found that its sources provide reliable and valid data for compliance reporting, ratings of "met*" are not yet final and cannot be used for Compliance determinations, but rather are for illustrative purposes only.

10. Regional Quality Councils

Background

The role of the Commonwealth's five Regional Quality Councils (RQCs) is to identify regional or service system-wide deficiencies for individuals with IDD, and to recommend quality improvement (QI) initiatives to resolve them.

The Agreement specified in Provisions V.D.5. and V.D.5.b. that DBHDS would develop and implement these RQCs, whose membership would comprise service system stakeholders and be staffed by the Department. DBHDS's Quality Improvement Committee (QIC) would direct the Councils' operations. The Agreement assigned the RQCs the responsibilities of assessing relevant data, identifying trends, and recommending responsive actions to improve services in their respective Regions.

In the review conducted during the Seventeenth Period in 2020, the Independent Reviewer's consultant confirmed aspects of the structure and operations of the RQCs. Their Charter contained all essential elements agreed to by the Parties, and the membership of the Councils complied with the requirements. Also, each of the five RQCs had convened regular quarterly meetings, with meeting minutes kept and approved by the members. Overall, attendance was consistently good.

Regarding functionality, Council members discussed the data reports presented by DBHDS staff assigned to the RQCs. Members reported that the preparation and presentation of data continued to be an evolving process, as a result of ongoing focused improvement efforts to increase the accuracy and validity of the data presented. However, DBHDS could not verify that the data presented or their sources were reliable.

Council members also cited greater consistency in the content of their QI initiatives submitted to the QIC. The Seventeenth Period study confirmed that each RQC had submitted one QI initiative with one measurable outcome. The QIC did not approve any of these submissions, however,

returning each of the proposed initiatives back to the Councils with comments and instructions for further improvement. The most commonly identified instruction was the need to narrow the scope of the initiative to allow reasonable assurance that it could be implemented, and that data could be generated to measure its impact and effectiveness.

The critical elements of the RQC's role – data analysis and the planning and development of recommendations – continued to evolve but were still at an early stage during the Seventeenth Period. The Councils were not adequately fulfilling the essential data analysis and planning elements, which were prerequisites for developing effective recommendations for regional QI initiatives.

The accuracy of the data presented by DBHDS was reported by RQC members to be improving. However, since the Department had not verified the reliability of its data sources, Virginia did not meet the relevant Indicator.

Based on the Seventeenth Period study, the Independent Reviewer determined that the Commonwealth met three of Provision V.D.5.'s Indicators. For Provision V.D.5.b., Virginia achieved five of the seven Indicators.

Nineteenth Period Study

For the latest study, the Independent Reviewer retained the same consultant to examine the Commonwealth's progress toward the implementation of RQCs and the achievement of Provisions V.D.5. and V.D.5.b., together with their respective Compliance Indicators.

This review studied the progress DBHDS made in each of the five Regions. All had convened regular quarterly meetings of their appointed Council, achieving a quorum each time, and served as a subcommittee to the QIC. The RQC minutes for the last two quarters of Fiscal Year 2021 showed significant improvement over the first two quarters in terms of specific data provided for review and the relevance to the roles and responsibilities of the Councils, as defined in their charters.

All five RQCs had recommended and implemented a QI initiative that also reflected significant improvement in their use of data. However, while the Councils had improved their processes for reviewing and evaluating data, trends, and monitoring efforts, and for using those efforts to recommend annual QI initiatives to the QIC, their work was compromised by a lack of measurable

outcomes and valid and reliable data. Once again, DBHDS did not find that the sources of its data shared with the RQCs were reliable and valid for compliance reporting.

See the consultant's full report in Appendix H.

Conclusion

The Nineteenth Period study concluded that Virginia has met eight of the 12 Compliance Indicators for Provisions V.D.5. (39.01–39.05) and V.D.5.b. (40.01–40.07), compared with having met eight of these Indicators during the Seventeenth Period's review.

Regarding Provision V.D.5., the Commonwealth has met three Compliance Indicators 39.01–39.03, but has not achieved two Indicators 39.04–39.05. Therefore, Virginia remains in Non-Compliance with this Provision.

Regarding Provision V. D.5.b., the Commonwealth has met five Compliance Indicators 40.01, 40.02*, 40.03, 40.04 and 40.06, but has not achieved two Indicators 40.05 and 40.07. Therefore, Virginia remains in Non-Compliance with this Provision.

* *Note*: Since DBHDS has not yet found that its sources provide reliable and valid data for compliance reporting, ratings of "met*" are not yet final and cannot be used for Compliance determinations, but rather are for illustrative purposes only.

11. Public Reporting

Background

The purpose of the Compliance Indicators associated with Public Reporting's Provisions V.D.6. and IX.C. are to provide information for the public about the availability and quality of supports and services, and the gaps in such services, as well as related records, per the Agreement, for the Independent Reviewer. This documentation includes demographics about individuals with IDD who are served, as well as the capacity of services either provided or available to them.

The Commonwealth is expected to publish an *Annual Quality Management Report and Evaluation* that includes reported data regarding performance measures, QI initiatives and systemic challenges. Additional reports, including those related to licensing inspections and investigations, QSRs and

the National Core Indicators, are also to be released publicly. Further information is to be posted and updated at least annually on either the Library or the DBHDS website.

During the Seventeenth Review Period in 2020, Virginia launched its Library index as its venue for public reporting. This included many of the documents required by the relevant Indicators.

Also, DBHDS published the *Provider Data Summary* in May 2020. Although it covered the required topics in detail, the Summary acknowledged that additional work was still needed to ensure the reliability of all reported data.

In addition, the Department issued a *Quality Management Plan: Annual Report and Evaluation, State Fiscal Year 2019*. This included information and data covering all the defined topics but was almost a year old when it was made publicly available. Outdated information is not sufficient for providing a status report to the public or for developing actionable quality improvements. DBHDS already recognized these shortcomings and planned for their next report for Fiscal Year 2020 to be made available much more quickly, after the close of the first quarter of Fiscal Year 2021.

Based on the Seventeenth Period study, the Independent Reviewer determined that the Commonwealth had not achieved Provision IX.C., and had not met Provision V.D.6.'s five Indicators.

Nineteenth Period Study

For the latest study, the Independent Reviewer retained the same consultant to again examine the progress DBHDS had made toward the availability and quality of supports and services for public reporting.

For this Period, Virginia did not meet any of the Indicators for the two associated Provisions. This was due primarily to DBHDS's failure to post or update the required records, including annual updates to the specified documents, on the Library website.

See Appendix H for the full report.

Conclusion

Regarding Provision V.D.6., the Nineteenth Period study concluded that the Commonwealth has not met any of the associated five Compliance Indicators (41.01–41.05). Therefore, Virginia remains in Non-Compliance with this Provision.

Regarding Provision IX.C., the Commonwealth has not met any of the associated four Compliance Indicators (54.01–54.04). Therefore, Virginia remains in Non-Compliance with this Provision.

III. CONCLUSION

During the Nineteenth Review Period, Virginia, through its lead agencies DBHDS and DMAS, and their sister agencies, continued its diligent efforts and progress toward fulfilling the requirements of the remaining Provisions of the Agreement. The Commonwealth met 100 (60%) of the 166 Compliance Indicators studied during this Period. Of these, Virginia achieved 48 Indicators for the first time. Accomplishments include:

- The Office of Licensing (OL) effectively demonstrated its licensing process with assessments of the adequacy of provider supports and services;
- The Mortality Review Committee (MRC) improved its determinations of potentially preventable deaths and the effectiveness of its quality improvement initiatives; and
- The Regional Support Teams strengthened their functioning, resulting in meeting the requirements of ten Indicators for the first time.

Substantial and unresolved obstacles, however, continued to interfere with the Commonwealth's ability to achieve the remaining Indicators. Chief among them are:

- Virginia's data sources have still not been determined by DBHDS to provide reliable and valid data for compliance reporting.
- DBHDS's various quality review processes have not yet demonstrated adequate functioning. This is hampering the development and implementation of effective quality improvement initiatives.
- The Commonwealth continues to lack an effective process to monitor and determine the extent to which providers ensure that all their staff complete the required competency and related training requirements of the DMAS regulations.

Together, these primary obstacles continue to significantly impede the functionality of Virginia's quality and risk management system.

Moving forward, the Independent Reviewer strongly recommends that the Commonwealth concentrate immediately on resolving the issue of the lack of reliable and valid data. This is an essential step toward Virginia developing an effective quality and risk management system and achieving many of the remaining Indicators.

Since the end of the Nineteenth Review Period, the Parties agreed to curative actions that the Commonwealth would take to achieve compliance. Virginia's agreement to undertake these actions represents the considerable effort still required by the Commonwealth to improve its service system for individuals with IDD. This agreement also signifies Virginia's commitment to accomplishing the remaining Provisions of the Settlement Agreement.

For the Twentieth Review Period, in addition to completing targeted analysis and providing feedback to the Parties, the Independent Reviewer plans to study the status of the Commonwealth's progress toward fulfilling the requirements of the Provisions in the following areas:

- Creation of Waiver slots;
- Individual and Family Support Program;
- Case Management;
- Crisis Services;
- Peer to peer/family to family programs and guidelines for families;
- Serving individuals in the most integrated setting;
- Independent living options;
- Serving individuals with complex medical needs;
- Quality and Risk Management System (specifically Provisions V.B. and V.C.1.); and
- Quality Service Reviews.

Throughout this Nineteenth Review Period, Virginia's staff and DOJ gathered and shared information that helped to facilitate further progress toward effective implementation of the Agreement's Provisions. Overall, the willingness of both Parties to openly and regularly discuss implementation issues, as well as any concerns about progress and possible solutions has been critical and productive. The involvement and contributions of the advocates and other stakeholders have helped the Commonwealth to formulate policies and processes and make measurable progress toward fulfilling its promises to all the citizens of Virginia, especially those with IDD and their families.

The Independent Reviewer greatly appreciates the assistance that was so generously given by the individuals at the heart of this Agreement, as well as their families, their case managers and their service providers.

IV. RECOMMENDATIONS

The Independent Reviewer recommends that the Commonwealth undertake the twelve actions listed below, and provide a report that addresses these recommendations and their status of implementation by March 31, 2022. Virginia should also consider the additional recommendations and suggestions included in the consultants' reports, which are contained in the Appendices. The Independent Reviewer will study the implementation and impact of these recommendations during the Twenty-first Review Period (October 1, 2021 – March 31, 2022).

1. DBHDS should place a primary, urgent emphasis on remedies and improvements needed to determine that its data source systems and Performance Measure Indicator (PMI) data collection methodologies provide reliable and valid data for compliance reporting.

2. The Commonwealth should enhance its efforts to ensure the availability of a sufficient number of qualified behavioral specialists and experienced residential and day service providers with the capacity to meet the needs of individuals with intense behaviors who have DD Waiver-funded services.

3. DBHDS should review each of the discrepancies between the findings of this Period's Individual Services Review (ISR) study and those of the 2020 Quality Service Reviews (QSR) study. The Department should then determine whether the ISR findings of service needs not being met are accurate. If the ISR clinicians' findings are verified, DBHDS should review the root cause(s) of the QSR auditors' failure to identify these service inadequacies, and take needed corrective actions.

4. DBHDS should establish minimum qualifications and extend orientation and specialized training for QSR auditors to ensure that, at the time of the QSR reviews, they have sufficient clinical awareness of the service needs for individuals with IDD, especially those with health and safety needs.

5. Virginia should document its methodology for monitoring and verifying the extent to which its providers have policies and procedures in place and have ensured that all Direct Support Professionals and their supervisors have met the training and competency regulatory requirements specified at 12vac30-122-180.

6. DBHDS should implement policies and procedures that ensure providers maintain and report provider reporting measure data from their quality improvement programs.

7. DMAS should finalize and implement transportation measures that assess on-time performance, based on billing-encounter data, so that the Department has two successive quarters of reliable transportation data for non-emergency medical transportation (NEMT).

8. DBHDS's Mortality Review Committee should expand and align its four categories of preventable death with national standards to improve its ability to make recommendations and to develop quality improvement initiatives for regional or statewide implementation.

9. The Commonwealth should establish criteria for what constitutes a meaningful discussion between case managers and the individuals served regarding their interest in employment. Criteria should include discussion of the person's interests and any employment history; their skills related to employment; the employment services available through DARs and HCBS Waivers; and the barriers to successful employment that they or their family feel exist.

10. DBHDS should document the criteria for the measurability aspect of its Specific Measurable Achievable Relevant and Time-Based (SMART) goals and recommendations. The Department should also document its methodology for ensuring that its Regional Quality Councils develop recommendations that meet these criteria.

11. DBHDS should maintain and update its Library site to include all documents needed to create a framework for implementing and sustaining each Provision, e.g. regulations, policies, instructions, procedures and protocols. The Department should ensure that there are sufficient resources and an adequate structure in place so it adheres to the expectations described in its *DOJ Settlement Agreement Library Protocol*, including the timelines for, at minimum, annual report production and protocols for an annual audit.

12. DMAS should produce its Quality Review Team's end-of-year report within six months of the year end, so the report can be utilized more effectively for quality improvement purposes.

V. SUMMARY OF COMPLIANCE

Note: Previously, for greater clarity, Virginia created a numbering system that assigned a discrete number for each Compliance Indicator. The Independent Reviewer has now adopted this system; these numbers can be seen below in the Comments column for Provisions.

Settlement Agreement Reference	Provision	Compliance Rating	Comments
III	**Serving Individuals with Developmental Disabilities in the Most Integrated Setting**	Ratings prior to the 19th Period are not in bold. Ratings for the 19th Period are in **bold.** If Compliance ratings have been achieved twice consecutively, Virginia has achieved "Sustained Compliance."	Comments include the Commonwealth's status with each of the Compliance Indicators associated with the provision. The Findings Section and attached consultant reports include explanatory information regarding the Compliance Indicators. *The Comments in italics below are from a prior period when the most recent compliance rating was determined.*
III.C.1.a.i.-x.	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 … x.	Sustained Compliance	*The Commonwealth created more than the required number of waiver slots, and it prioritized slots for the designated target populations, as required over the ten years FY 2012-2021.*

Settlement Agreement Reference	Provision	Compliance Rating	Comments
III.C.1.b.i.-x.	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) … ix.	Sustained Compliance	*The Commonwealth created more than the required number of waiver slots, and it prioritized slots for the designated target populations, as required over the ten years FY 2012-2021.* *The Parties agreed to consider the effectiveness of the discharge and transition process at Nursing Facilities (NFs) and ICFs as an indicator of compliance for III.D.1.*
III.C.1.c.i.-x.	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) … ix.	Sustained Compliance	*See Comment re: III.C.1.b.i-ix*
III.C.2.a.-h.	The Commonwealth shall create an Individual and Family Support Program (IFSP) for individuals with ID/DD whom the Commonwealth determines to be the most at risk of institutionalization. In the State Fiscal Year 2021, a minimum of 1,000 individuals will be supported.	Non Compliance Non Compliance	*The Commonwealth has fulfilled the quantitative requirement for the Fiscal Years 2013 through 2020 by providing financial support to more than 1,000 individuals each year. During the 18th Period, the Commonwealth met the requirements for five of the twelve Compliance Indicators, 1.01-1.12. The Commonwealth met Indicators 1.03, 1.05, 1.08, 1.10, and 1.12. It has not met 1.01, 1.02, 1.04, 1.06, 1.07, 1.09, and 1.11, and therefore remains in non-compliance.*

Settlement Agreement Reference	Provision	Compliance Rating	Comments
III.C.5.a.	The Commonwealth shall ensure that individuals receiving HCBS waiver services under this Agreement receive case management.	Sustained Compliance	*187(100%) of the individuals reviewed in the Individual Services Review studies during the 10th, 11th, 12th, 13th, 14th, 15th, 16th and 18th Periods had case managers and current Individual Support Plans.*
III.C.5.b.	For the purpose of this agreement, case management shall mean:		
III.C.5.b.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.	Non Compliance Non Compliance	*For this and four other Provisions, III.C.5.b.ii., III.C.5.b.iii.., III.C.5.c. and V.F.2., there are twelve Compliance Indicators, 2.01-2.05 and 2.16-2.22. Indicator 2.05 has ten required elements (2.06-2.15).* *Virginia met four of the Indicators 2.01, 2.04, 2.17 and 2.21, but has not met eight Indicators 2.02, 2.03, 2.05 (includes 2.06 – 2.15), 2.16, 2.18, 2.19, 2.20, and 2.22.*
III.C.5.b.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.	Non Compliance Non Compliance	*When Virginia achieves the Indicators for III.C.5.b.i., it also achieve compliance for this Provision.*
III.C.5.b.iii.	Monitoring the ISP to make timely additional referrals, service changes, and amendments to the plans as needed.	Non Compliance Non Compliance	*When Virginia achieves the Indicators for III.C.5.b.i., it also achieve compliance for this Provision.*

Settlement Agreement Reference	Provision	Compliance Rating	Comments
III.C.5.c.	Case management shall be provided to all individuals receiving HCBS waiver services under this Agreement by case managers who are not directly providing such services to the individual or supervising the provision of such services. The Commonwealth shall include a provision in the Community Services Board ("CSB") Performance Contract that requires CSB case managers to give individuals a choice of service providers from which the individual may receive approved waiver services and to present practicable options of service providers based on the preferences of the individual, including both CSB and non-CSB providers.	**Sustained Compliance**	The Independent Reviewer and Parties agreed in April 2020 that this provision is in Sustained Compliance.
III.C.5.d.	The Commonwealth shall establish a mechanism to monitor compliance with performance standards.	Non Compliance Non Compliance	*The Commonwealth met three of the four Compliance Indicators, 6.01-6.04. It met 6.01, 6.02, and 6.03., but has not met Indicator 6.04, and therefore remains in Non-Compliance.*
III.C.6.a.i.-iii.	The Commonwealth shall develop a statewide crisis system for individuals with intellectual and developmental disabilities. The crisis system shall: i. Provide timely and accessible support … ii. Provide services focused on crisis prevention and proactive planning … iii. Provide in-home and community-based crisis services that are directed at resolving crises and preventing the removal of the individual from his or her current placement whenever practicable.	Non Compliance Non Compliance	*The Commonwealth met twelve* of the twenty-two Compliance Indicators 7.02-7.23. It met Indicators 7.2, 7.3, 7.4, 7.5*, 7.9*, 7.10, 7.11, 7.12*, 7.13*, , and* 7.15, 7.17*, and 7.23, but has not met Indicators 7.6, 7.7, 7.8, 7.14, 7.16, 7.18, 7.19, 7.20, 7.21, 7.22, and therefore remains in Non-Compliance.*

Settlement Agreement Reference	Provision	Compliance Rating	Comments
III.C.6.b.i.A.	The Commonwealth shall utilize existing CSB Emergency Services, including existing CSB hotlines, for individuals to access information about referrals to local resources. Such hotlines shall be operated 24 hours per day, 7 days per week.	Sustained Compliance	*CSB Emergency Services are utilized. Regional Education, Assessment, Crisis Services, Habilitation (REACH) hotlines are operated 24 hours per day, 7 days per week, and provide access to information for adults and children with IDD.*
III.C.6.b.i.B.	By June 30, 2012, the Commonwealth shall train CSB Emergency Services (ES) personnel in each Health Planning Region on the new crisis response system it is establishing, how to make referrals, and the resources that are available.	Sustained Compliance	*REACH trained CSB staff during the past six years. The Commonwealth requires that all Emergency Services (ES) staff and case managers are required to attend training*.
III.C.6.b.ii.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.	Non Compliance Non Compliance	*The Commonwealth met five*, of the seven Compliance Indicators 8.01-8.07. It met Indicators 8.01, 8.02, 8.03, 8.05, and 8.07, but has not met 8.04 and 8.06, and therefore remains in Non-Compliance.*
III.C.6.b.ii.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.	Non Compliance Non Compliance	*The Parties agreed that the Indicators for III.C.6.a.i.-iii. and III.C.6.b.ii.A. cover this provision.*
III.C.6.b.ii.C.	Mobile crisis team members adequately trained to address the crisis also shall work with law enforcement personnel to respond if an individual with IDD comes into contact with law enforcement.	Sustained Compliance	*During the 17th and 18th Review Periods, law enforcement personnel were involved. Mobile crisis team members worked with law enforcement personnel to respond regardless of whether REACH staff responded in person or remotely using telehealth.*

Settlement Agreement Reference	Provision	Compliance Rating	Comments
III.C.6.b.ii.D.	Mobile crisis teams shall be available 24 hours per day, 7 days per week and to respond on-site to crises.	Sustained Compliance	*REACH Mobile crisis teams for children and adults are available around the clock and respond on-site, or remotely due to COVID precautions, at all hours of the day and night.*
III.C.6.b.ii.E.	Mobile crisis teams shall provide local and timely in-home crisis support for up to three days, with the possibility of an additional period of up to 3 days upon review by the Regional Mobile Crisis Team Coordinator	Sustained Compliance	*In each Region, the individuals are provided in-home mobile supports, or telehealth due to COVID precautions, for up to three days as required. Days of support provided ranged between a low of one and a high of sixteen days.*
III.C.6.b.ii.H.	By June 30, 2014, the Commonwealth shall have a sufficient number of mobile crisis teams in each Region to respond to on-site to crises as follows: in urban areas within one hour, in rural areas within two hours, as measured by the average annual response time.	Sustained Compliance	*The Commonwealth added staff to REACH teams in all five Regions and for five years demonstrated a sufficient number of staff to respond to on-site crises within the required average annual response times. Appropriate COVID precautions temporarily replaced most on-site responses.*
III.C.6.b.iii.A.	Crisis Stabilization programs offer a short-term alternative to institutionalization or hospitalization for individuals who need inpatient stabilization services.	Sustained Compliance	*All Regions continue to have crisis stabilization programs that are providing short-term alternatives for adults and have two crisis stabilization homes for children.*
III.C.6.b.iii.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.	Non Compliance Non Compliance	*The Commonwealth met the four* Compliance Indicators 10.01, 10.2, 10.3*, and -10.04*, however, it remains in Non-Compliance. See *Note at the end of this Table.*
III.C.6.b.iii.D.	Crisis stabilization programs shall have no more than six beds and lengths of stay shall not exceed 30 days.	Non Compliance	*For illustrative purposes only, the Commonwealth met the sole indicator* 11.01, however, it*

Settlement Agreement Reference	Provision	Compliance Rating	Comments
		Non Compliance	*remains in Non-Compliance. See *Note at the end of this Table.*
III.C.6.b.iii.E.	With the exception of the Pathways Program at SWVTC … crisis stabilization programs shall not be located on the grounds of the Training Centers or hospitals with inpatient psychiatric beds. By July 1, 2015, the Pathways Program at SWVTC will cease providing crisis stabilization services and shall be replaced by off-site crisis stabilization programs with sufficient capacity to meet the needs of the target population in that Region.	Non Compliance Compliance	*The Parties agreed that the Indicators for III.C.6.b.iii.G. cover this Provision.*
III.C.6.b.iii.F.	By June 30, 2012, the Commonwealth shall develop one crisis stabilization program in each Region.	Sustained Compliance	*Each Region developed and currently maintains a crisis stabilization program for adults with IDD in each Region and has two programs for children.*
III.C.6.b.iii.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.	Non Compliance Compliance	*The Commonwealth met all three Compliance Indicators 13.01, 13.02, and13.03, and therefore has achieved Compliance for the first time.*
III.C.7.a.	To the greatest extent practicable, the Commonwealth shall provide individuals in the target population receiving services under this Agreement with integrated day opportunities, including supported employment.	Non Compliance **Non Compliance**	The Commonwealth has achieved Compliance Indicator 14.01. The Commonwealth has not met Indicators 14.02 14.03, 14.04, 14.05, 14.06, 14.07. 14.08, 14.09, and 14.10.

Settlement Agreement Reference	Provision	Compliance Rating	Comments
III.C.7.b.	The Commonwealth shall maintain its membership in the State Employment Leadership Network ("SELN") established by the National Association of State Developmental Disabilities Directors. The Commonwealth shall establish a state policy on Employment First for the target population and include a term in the CSB Performance Contract requiring application of this policy. 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 the ISP. The Commonwealth shall have at least one employment service coordinator to monitor implementation of Employment First practices for individuals in the target population.	Non Compliance **Non Compliance**	The indicators for III.C.7.a. serve to measure III.C.7.b.
III.C.7.b.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 recreation opportunities, and other integrated day activities.	**Sustained Compliance**	The Commonwealth had previously developed plans for both supported employment and for integrated community activities. It's updated plan includes outcomes and bench marks for FY 21 –FY23
III.C.7.b.i.A.	Provide regional training on the Employment First policy and strategies through the Commonwealth.	**Sustained Compliance**	DBHDS continued to provide regional training.

Settlement Agreement Reference	Provision	Compliance Rating	Comments
III.C.7.b.i. B.1.	Establish, for individuals receiving services *through the HCBS waivers*, annual baseline information regarding:	**Sustained Compliance**	The Commonwealth has sustained its improved method of collecting data. For the fifth consecutive full year, data were reported by 100% of the employment service organizations. They continue to report the number of individuals, length of time, and earnings as required in III.C.7.b.i.B.1.a., b., c., d., and e. below.
III.C.7.b.i. B.1.a.	The number of individuals who are receiving supported employment.	**Sustained Compliance**	See answer for III.C.7.b.i.B.1.
III.C.7.b.i. B.1.b.	The length of time individuals maintain employment in integrated work settings.	**Sustained Compliance**	See answer for III.C.7.b.i.B.1.
III.C.7.b.i. B.1.c.	Amount of earnings from supported employment;	**Sustained Compliance**	See answer for III.C.7.b.i.B.1.
III.C.7.b.i. B.1.d.	The number of individuals in pre-vocational services.	**Sustained Compliance**	See answer for III.C.7.b.i.B.1.
III.C.7.b.i. B.1.e.	The length-of-time individuals remain in pre-vocational services.	**Sustained Compliance**	See answer for III.C.7b.i.B.1.
III.C.7.b.i. B.2.a.	Targets to meaningfully increase: the number of individuals who enroll in supported employment each year.	**Sustained Compliance**	The Parties agreed in January 2020 that this provision is in Sustained Compliance and that meeting these targets will be measured in III.D.1.
III.C.7.b.i. B.2.b.	The number of individuals who remain employed in integrated work settings at least 12 months after the start of supported employment.	**Sustained Compliance**	Th number of individuals employed and the length of time employed are both determined annually.

Settlement Agreement Reference	Provision	Compliance Rating	Comments
III.C.7.c.	Regional Quality Councils (RQC), described in V.D.5. … shall review data regarding the extent to which the targets identified in Section III.C.7.b.i.B.2 above are being met. These data shall be provided quarterly … Regional Quality Councils shall consult with providers with the SELN regarding the need to take additional measures to further enhance these services.	Sustained Compliance **Sustained Compliance**	RQCs did not completed a quarterly review of employment data or employment targets. Data were not shared with the RQC to review, and not all RQCs had evidence of meaningful discussions. RQC's did not consult with providers.
III.C.7.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.	Sustained Compliance **Sustained Compliance**	RQCs did not completed a quarterly review of employment data or employment targets. RQC's did not consult with providers.
III.C.8.a.	The Commonwealth shall provide transportation to individuals receiving HCBS waiver services in the target population in accordance with the Commonwealth's HCBS Waivers.	**Non Compliance** **Non Compliance**	The Commonwealth has achieved Compliance Indicators 16.01, 16.03, 16.04, 16.05, 16.06, and 16.07. The Commonwealth has not met Indicators 16.02 and 16.08.
III.C.8.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	Non Compliance Compliance	*The Commonwealth met the two Compliance Indicators 17.01 and 17.02 and therefore has achieved Compliance for the first time.*

Settlement Agreement Reference	Provision	Compliance Rating	Comments
III.D.1.	The Commonwealth shall serve individuals in the target population in the most integrated setting consistent with their informed choice and needs.	Non Compliance Non Compliance	*The Commonwealth met twelve*, of the twenty-three Indicators 18.01-18.23. It met Indicators 18.01*, 18.10, 18.11, 18.12, 18.13, 18.14, 18.15, 18.16, 18.17, 18.18, 18.19*, 18.22, but did it not meet the eleven Indicators 18.02, 18.03, 18.04, 18.05, 18.06, 18.07, 18.08, 18.09, 18.20, 18.21, and 18.23, and therefore remains in Non-Compliance.*
III.D.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.	Sustained Compliance	*As of 3/31/21, the Commonwealth had created new options for 1,562 individuals who are now living in their own homes. This is 1,221 more individuals than the 341 individuals who were living in their own homes as of 7/1/15. This accomplishment is 84% of its goal of 1,886 by 6/30/20.*
III.D.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.	Sustained Compliance	*The Commonwealth developed a plan, created strategies to improve access, and provided rental subsidies.*
III.D.3.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 ...	Sustained Compliance	*DBHDS has a dedicated housing service coordinator. It has developed and updated its housing plan with these representatives and with others.*

Settlement Agreement Reference	Provision	Compliance Rating	Comments
III.D.3.b.i.-ii.	The plan will establish for individuals receiving or eligible to receive services through the HCBS waivers under this Agreement: Baseline information regarding the number of individuals who would choose the independent living options described above, if available; and recommendations to provide access to these settings during each year of this Agreement.	Sustained Compliance	*Virginia estimated the number of individuals who would choose independent living options. It established the required baseline, updated and revised the Plan with new strategies and recommendations, and tracks progress toward achieving plan goals.*
III.D.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.	Sustained Compliance	*The Commonwealth established the one-time fund, distributed funds, and demonstrated viability of providing rental assistance. The individuals who received these one-time funds received permanent rental assistance.*
III.D.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.	Non Compliance Non Compliance	*The Commonwealth met one of the three Compliance Indicators 19.01-19.03. It met Indicator 19.01, but did not meet 19.02 and 19.03, and therefore remains in Non Compliance.*
III.D.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 (CRC) and, under circumstances described in Section III.E below, the Regional Support Team (RST).	Non Compliance **Non Compliance**	The Commonwealth has met Indicators 20.01, 20.03, 20.04*, 20.05, 20.06, 20.08*, 20.09, 20.10*, 20.11 and 20.13*; but has not achieved Indicators 20.02, 20.07 and 20.12. Therefore, Virginia remains in Non-Compliance with this Provision. See * *Note* below.

Settlement Agreement Reference	Provision	Compliance Rating	Comments
III.D.7.	The Commonwealth shall include a term in the annual performance contract with the CSBs to require case managers to continue to offer education about less restrictive community options on at least an annual basis to any individuals living outside their own home or family's home …	Sustained Compliance	*The Commonwealth included this term in its annual performance contract, developed and provided training to case managers and implemented an form for the annual ISP form process regarding education about less restrictive options.*
III.E.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 be a member of the Regional Support Team ...	**Sustained Compliance**	Community Resource Consultants (CRCs) are located in each Region, are members of the Regional Support Teams, and are utilized for these functions**.**
III.E.2.	The CRC may consult at any time with the Regional Support Team (RST). Upon referral to it, the RST shall work with the Personal Support Team ("PST") and CRC to review the case, resolve identified barriers, and ensure that the placement is the most integrated setting appropriate to the individual's needs, consistent with the individual's informed choice. The RST shall have the authority to recommend additional steps by the PST and/or CRC.	**Sustained Compliance**	DBHDS has sustained improved RST processes. CRCs and the RSTs continue to fulfill their roles and responsibilities.
III.E.3.a.-d.	The CRC shall refer cases to the Regional Support Teams (RST) for review, assistance in resolving barriers, or recommendations whenever (specific criteria are met).	**Sustained Compliance**	The RSTs, which meet monthly and fulfill their assigned functions when they receive timely referrals..

Settlement Agreement Reference	Provision	Compliance Rating	Comments
IV.	**Discharge Planning and Transition from Training Centers**	**COMPLIANCE*** designates the portions of the Consent Decree achieved by Virginia and relieved by the Court.	Comments explain the Commonwealth's status with each Provision.
IV.	By July 2012, the Commonwealth will have implemented Discharge and Transition Planning processes at all Training Centers consistent with the terms of this section	**COMPLIANCE***	The Commonwealth developed and implemented discharge planning and transition processes prior to July 2012. These processes continue at SEVTC.
IV.A.	To ensure that individuals are served in the most integrated setting appropriate to their needs, the Commonwealth shall develop and implement discharge planning and transition processes at all Training Centers consistent with the terms of this Section and person-centered principles.	**COMPLIANCE***	For the one area of Non-Compliance previously identified – lack of integrated day opportunities – the Parties established indicators for III.C.7.a to serve as the measures of compliance for IV.A.
IV.B.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.	**COMPLIANCE***	The Independent Reviewer's Individual Services Review studies found that DBHDS has consistently complied with this provision. The discharge plans reviewed were well organized and well documented.

Settlement Agreement Reference	Provision	Compliance Rating	Comments
IV.B.4.	The goal of treatment and discharge planning shall be to assist the individual in achieving outcomes that promote the individual's growth, wellbeing, and independence, based on the individual's strengths, needs, goals, and preferences, in the most integrated settings in all domains of the individual's life (including community living, activities, employment, education, recreation, healthcare, and relationships).	**COMPLIANCE***	For the one area of Non-Compliance previously identified – lack of integrated day opportunities – the Parties established indicators for III.C.7.a to serve as the measures of compliance for IV.B.4.
IV.B.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 will be developed within 30 days prior to discharge.	**COMPLIANCE***	The Independent Reviewer's Individual Services Review studies found that DBHDS has consistently complied with this provision and its sub provisions a.-e., e.i. and e.ii. The discharge plans are well documented.
IV.B.5.a.	Provision of reliable information to the individual and, where applicable, the authorized representative, regarding community options in accordance with Section IV.B.9;	**COMPLIANCE***	See comment re: IV.B.5.
IV.B.5.b.	Identification of the individual's strengths, preferences, needs (clinical and support), and desired outcomes;	**COMPLIANCE***	See comment re: IV.B.5.
IV.B.5.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;	**COMPLIANCE***	See comment re: IV.B.5.

Settlement Agreement Reference	Provision	Compliance Rating	Comments
IV.B.5.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.	**COMPLIANCE***	See comment re: IV.B.5.
IV.B.5.e.	Documentation of barriers preventing the individual from transitioning to a more integrated setting and a plan for addressing those barriers.	**COMPLIANCE***	See comment re: IV.B.5.
IV.B.5.e.i.	Such barriers shall not include the individual's disability or the severity of the disability.	**COMPLIANCE***	See comment re: IV.B.5.
IV.B.5.e.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.	**COMPLIANCE***	See comment re: IV.B.5.
IV.B.6.	Discharge planning will be done by the individual's PST…Through a person-centered planning process, the PST will assess an individual's treatment, training, and habilitation needs and make recommendations for services, including recommendations of how the individual can be best served.	**COMPLIANCE***	For the one area of Non-Compliance previously identified – lack of integrated day opportunities – the Parties established indicators for III.C.7.a to serve as the measures of compliance for IV.B.6.
IV.B.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.	**COMPLIANCE***	The Commonwealth's discharge plans indicate that individuals with complex/intense needs can live in integrated settings. Interviews and documents reviewed indicate that this process remains in place at SEVTC.

Settlement Agreement Reference	Provision	Compliance Rating	Comments
IV.B.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 these options.	**COMPLIANCE***	The Individual Services Review studies determined that individuals and their authorized representatives, were provided with information regarding community options and had the opportunity to discuss them with the PST. Interviews and documents reviewed indicate that this process remains in place at SEVTC.
IV.B.9.a.	The individual shall be offered a choice of providers consistent with the individual's identified needs and preferences.	**COMPLIANCE***	The Independent Reviewer's Individual Services Review studies found that Commonwealth had offered a choice of providers. Interviews and documents reviewed indicate that this process remains in place at SEVTC.
IV.B.9.b.	PSTs and the CSB case manager shall coordinate with the … community providers identified in the discharge plan as providing appropriate community-based services for the individual, to provide individuals, their families, and, where applicable, their authorized representatives with opportunities to speak with those providers, visit community placements (including, where feasible, for overnight visits) and programs, and facilitate conversations and meetings with individuals currently living in the community and their families, before being asked to make a choice regarding options. The Commonwealth shall develop family-to-family peer programs to facilitate these opportunities.	**COMPLIANCE***	The Individual Services Review studies determined that individuals and their authorized representatives did have an opportunity to speak with individuals currently living in their communities and their family members. Interviews and documents reviewed indicate that this process remains in place at SEVTC.
IV.B.9.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	**COMPLIANCE***	The Individual Services Review studies determined that PSTs and case managers assisted individuals and their Authorized Representative. Interviews and documents

Settlement Agreement Reference	Provision	Compliance Rating	Comments
	are timely identified and engaged in preparing for the individual's transition.		reviewed indicate that this process remains in place at SEVTC.
IV.B.11.	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.	**COMPLIANCE***	The Individual Services Review studies determined that individuals /Authorized Representatives who transitioned from Training Centers were provided with information regarding community options. Interviews and documents reviewed indicate that this process remains in place at SEVTC.
IV.B.11.a.	In collaboration with the CSB and Community providers, the Commonwealth shall develop and provide training and information for Training Center staff about the provisions of the Agreement, staff obligations under the Agreement, current community living options, the principles of person-centered planning, and any related departmental instructions. The training will be provided to all applicable disciplines and all PSTs.	**COMPLIANCE***	The Independent Reviewer confirmed that training has been provided. Interviews and documents reviewed indicate that this process remains in place at SEVTC.
IV.B.11.b.	Person-centered training will occur during initial orientation and through annual refresher courses. Competency will be determined through documented observation of PST meetings and through the use of person-centered thinking coaches and mentors. Each Training Center will have designated coaches who receive additional training. The coaches will provide guidance to PSTs to ensure implementation of the person-centered tools and skills. Coaches … will have regular and structured sessions and person-centered thinking mentors. These sessions will be designed to foster additional skill development and ensure implementation of person centered thinking practices throughout all levels of the Training Centers.	**COMPLIANCE***	The Independent Reviewer confirmed that staff receive required person-centered training during orientation and annual refresher training. Interviews and documents reviewed indicate that this process remains in place at SEVTC.

Settlement Agreement Reference	Provision	Compliance Rating	Comments
IV.B.15.	In the event that a PST makes a recommendation to maintain placement at a Training Center or to place an individual in a nursing home or congregate setting with five or more individuals, the decision shall be documented, and the PST shall identify the barriers to placement in a more integrated setting and describe in the discharge plan the steps the team will take to address the barriers. The case shall be referred to the Community Integration Manager and Regional Support Team in accordance with Sections IV.D.2.a and f and IV.D.3 and such placements shall only occur as permitted by Section IV.C.6.	**COMPLIANCE***	See Comment for IV.D.3.
IV.C.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.	**COMPLIANCE***	The Independent Reviewer's Individual Services Review studies found that provider staff participated in the pre-move ISP meeting and were trained in the support plan protocols. Interviews and documents reviewed indicate that this process remains in place at South Eastern Virginia Training Center (SEVTC).
IV.C.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.	**COMPLIANCE***	The Independent Reviewer's Individual Services Review studies found that almost all individuals had moved within 6 weeks, or reasons were documented. Interviews and documents reviewed indicate that this process remains in place at SEVTC.

Settlement Agreement Reference	Provision	Compliance Rating	Comments
IV.C.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 (PMM) Checklist. The Commonwealth shall ensure those conducting Post Move Monitoring are adequately trained and a reasonable sample of look-behind Post Move Monitoring is completed to validate the reliability of the Post Move Monitoring process.	**COMPLIANCE***	The Independent Reviewer determined the Commonwealth's PMM process is well organized. It functions with increased frequency during the first weeks after transitions. The Independent Reviewer's Individual Services Review studies found that PMM visits occurred. The monitors had been trained and utilized monitoring checklists. Interviews and documents reviewed indicate that this process remains in place at SEVTC.
IV.C.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.	**COMPLIANCE***	The Independent Reviewer's Individual Services Review studies found that for almost all individuals, the Commonwealth updated discharge plans within 30 days prior to discharge. Interviews and documents reviewed indicate that this process remains in place at SEVTC.

Settlement Agreement Reference	Provision	Compliance Rating	Comments
IV.C.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.	**COMPLIANCE***	The Independent Reviewer's Individual Services Review studies found that the Personal Support Teams (PSTs), including the Authorized Representative, had determined and documented, and the CSBs had verified, that essential supports to ensure successful community placement were in place prior to placement. Interviews and documents reviewed indicate that this process remains in place at SEVTC.
IV.C.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.	**COMPLIANCE***	The Independent Reviewer's Individual Services Review studies found that discharge records for almost all individuals who moved to settings of five or more did so based on their informed choice after receiving options. Interviews and documents reviewed indicate that this process remains in place at SEVTC.
IV.C.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.	**COMPLIANCE***	The Independent Reviewer confirmed that documented Quality Assurance processes have been implemented consistent with the terms of the Agreement. When problems have been identified, corrective actions have occurred with the discharge plans. Interviews and documents reviewed indicate that this process remains in place at SEVTC.

Settlement Agreement Reference	Provision	Compliance Rating	Comments
IV.D.1.	The Commonwealth will create Community Integration Manager ("CIM") positions at each operating Training Center.	**COMPLIANCE***	The Independent Reviewer confirmed that the Facility Director job description at SEVTC specifically identifies responsibility for CIM duties and responsibilities.
IV.D.2.a.	CIMs shall be engaged in addressing barriers to discharge, including in all of the following circumstances: The PST recommends that an individual be transferred from a Training Center to a nursing home or congregate setting with five or more individuals.	**COMPLIANCE***	The Independent Reviewer's Individual Services Review studies found that CIMs were engaged in addressing barriers to discharge. Interviews and documents reviewed indicate that this process remains in place at SEVTC.
IV.D.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.	**COMPLIANCE***	The Independent Reviewer's Individual Services Review studies found that five RSTs were functioning with the required members and were coordinated by the CIMs. Interviews and documents reviewed indicate that this process remains in place at SEVTC.
IV.D.4.	The CIM shall provide monthly reports to DBHDS Central Office regarding the types of placements to which individuals have been placed.	**COMPLIANCE***	The CIM provides monthly reports and DBHDS provides the aggregated weekly and. monthly information to the Reviewer and DOJ.

Settlement Agreement Reference	Provision	Compliance Rating	Comments
V.	**Quality and Risk Management System**	Ratings prior to the 19th Period are <u>not</u> in bold. Ratings for the 19th Period are in **bold.** If Compliance ratings have been achieved twice consecutively, Virginia has achieved "Sustained Compliance."	Comments include the Commonwealth's status with each of the Compliance Indicators associated with the provision. The Findings Section and attached consultant reports include additional explanatory information regarding the Compliance Indicators. *The Comments in <u>italics</u> below are from a prior period when the most recent compliance rating was determined.*
V.B.	The Commonwealth's Quality Management System shall: identify and address risks of harm; ensure the sufficiency, accessibility, and quality of services to meet individuals' needs in integrated settings; and collect and evaluate data to identify and respond to trends to ensure continuous quality improvement.	Non Compliance Non Compliance	*The Commonwealth met eleven* of the thirty-three Compliance Indicators 29.01-29.33. It met Indicators 29.03, 29.04, 29.05, 29.06, 29.07, 29.11, 29.12, 29.13*, 29.15*, 29.31, and 29.32, but did not meet Indicators 29.01, 29.02, 29.08, 29.09, 29.10, 29.14, 29.16, 29.17, 29.18, 29.19, 29.20, 29.21, 29.12, 29.23, 29.24, 29.25, 29.26, 29.27, 29.28, 29.29, 29.30, and 29.33 and therefore remains in Non-Compliance.*
V.C.1.	The Commonwealth shall require that all Training Centers, CSBs, and other community providers of residential and day services implement risk management processes, including establishment of uniform risk triggers and thresholds, that enable them to adequately address harms and risks of harm.	Non Compliance Non Compliance	*The Commonwealth met five of the eleven Compliance Indicators 30.01-30.11. It met Indicators 30.01, 30.02, 30.03, 30.04, and 30.06, but did not meet Indicators 30.05, 30.07, 30.08, 30.09, 30.10, and 30.11, and therefore remains in Non-Compliance.*

Settlement Agreement Reference	Provision	Compliance Rating	Comments
V.C.2.	The Commonwealth shall have and implement a real time, web-based incident reporting system and reporting protocol.	**Sustained Compliance**	DBHDS implemented and maintains a web-based incident reporting system and reporting protocol.
V.C.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.	**Sustained Compliance**	DBHDS revised its regulations, increased the number of investigators and supervisors, added expert investigation training, created an Investigation Unit, includes double loop corrections in Corrective Action Plans (CAPs) for immediate and sustainable change, and requires 45-day checks to confirm implementation of CAP s re: health and safety.
V.C.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.	Non Compliance **Non Compliance**	The Commonwealth has met Compliance Indicators 32.01, 31.02, 31.05, 31.06, 31.08, and 31.09. The Commonwealth has not met Indicators 32.03, 32.04, and 32.07.
V.C.5.	The Commonwealth shall conduct monthly mortality reviews for unexplained or unexpected deaths reported through its incident reporting system. The …mortality review team … shall have at least one member with the clinical experience to conduct mortality re who is otherwise independent of the State. Within ninety days of a death, the mortality review team shall: (a) review, or document the unavailability of: (i) medical records, including physician case notes and nurse's notes, and all incident reports, for the three months preceding the individual's death; … (b) interview, as warranted, any persons having information regarding the individual's care; and (c) prepare and deliver to the DBHDS	Non Compliance **Non Compliance**	The Commonwealth has met Compliance Indicators 33.01, 33.02, 33.03, 33.04, 33.05, 33.06, 33.07, 33.08, 33.09*, 33.10, 33.11, 33.12, 33.14, 33.16, 33.17, 33.18, 33.19, 33.20, and 33.21. The Commonwealth has not met Indicators 33.13 and 33.15.

Settlement Agreement Reference	Provision	Compliance Rating	Comments
	Commissioner a report of deliberations, findings, and recommendations, if any. The team also shall collect and analyze mortality data to identify trends, patterns, and problems … and implement quality improvement initiatives to reduce mortality rates to the fullest extent practicable.		
V.C.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.	**Non Compliance** **Non-Compliance**	The Commonwealth has met Compliance Indicators 34.01, 34.02, 34.03, 34.04*, 34.06*, 34.07, and 34.08*. The Commonwealth has not met Indicator 34.05.
V.D.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. Review of data shall occur at the local and State levels by the CSBs and DMAS/DBHDS, respectively.	Non Compliance **Non Compliance**	The Commonwealth has met Compliance Indicators 35.02, 32.04. The Commonwealth has not met Indicators 35.01, 32.03, 35.05, 32.06, 35.07, and 32.08.
V.D.2.a.-d.	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.	Non Compliance **Non Compliance**	The Commonwealth has met Compliance Indicators 36.02* and , 36.07*. The Commonwealth has not met Compliance Indicators 36.01, 36.03, 36.04, 36.05, 36.06 and 36.08.

Settlement Agreement Reference	Provision	Compliance Rating	Comments
V.D.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 are collected and analyzed from each of these areas by June 30, 2014. Multiple types of sources (e.g., providers, case managers, licensing, risk management, Quality Service Reviews) can provide data in each area, though any individual type of source need not provide data in every area (as specified):	Non Compliance **Non Compliance**	The Commonwealth has met Compliance Indicators 37.01*, 37.03, 37.04, 37.08, 37.09, 37.10*, 37.11, 37.12*, 37.13, , 37.14*, 37.15, 37.16*, 37.18*, 37.19, 37.20*, 37.21, 37.22*, 37.23and 37.24*.. The Commonwealth has not met Indicators 37.02, 37.05, 37.06, 37.07, and 37.17
V.D.4.	The Commonwealth shall collect and analyze data from available sources, including the risk management system described in V.C. above, those sources described in Sections V.E-G and I below (e.g. providers, case managers, Quality Service Reviews, and licensing), Quality Service Reviews, the crisis system, service and discharge plans from the Training Centers, service plans for individuals receiving waiver services, Regional Support Teams, and CIMs.	Non Compliance **Non Compliance**	The Commonwealth has not met Compliance Indicator 38.01.
V.D.5.	The Commonwealth shall implement Regional Quality Councils (RQCs) that shall be responsible for assessing relevant data, identifying trends, and recommending responsive actions in their respective Regions of the Commonwealth.	Non Compliance **Non Compliance**	The Commonwealth has met Compliance Indicators 39.01, 39.02, and 39.03. The Commonwealth has not met Indicators 39.04, and 39.05.
V.D.5.a.	The Councils shall include individuals experienced in data analysis, residential and other providers, CSBs, individuals receiving services, and families, and may include other relevant stakeholders.	**Sustained Compliance**	The five Regional Quality Councils include all the required members.
V.D.5.b.	Each Council shall meet on a quarterly basis to share regional data, trends, and monitoring efforts and plan and recommend regional quality improvement initiatives. The work of the Regional Quality Councils shall	Non Compliance	The Commonwealth has met Compliance Indicators 40.01, 40.02*, 40.03, 40.04, and 40.06.

Settlement Agreement Reference	Provision	Compliance Rating	Comments
	be directed by a DBHDS quality improvement committee.	**Non Compliance**	The Commonwealth has not met Indicators 40.05 and 40.07.
V.D.6.	At least annually, the Commonwealth shall report publicly, through new or existing mechanisms, on the availability … and quality of supports and services in the community and gaps in services, and shall make recommendations for improvement.	Non Compliance **Non Compliance**	The Commonwealth has not met Indicators 41.01, 41.02, 41.03, 41.04, and 41.05.
V.E.1.	The Commonwealth shall require all providers (including Training Centers, CSBs, and other community providers) to develop and implement a quality improvement ("QI") program including root cause analysis that is sufficient to identify and address significant issues.	Non Compliance **Non Compliance**	The Commonwealth has met Compliance Indicator 42.01 and 42.02. The Commonwealth has not met Indicators 42.03, 42.04 and 42.05.
V.E.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.	Non Compliance **Non Compliance**	The Commonwealth has not met Indicators 43.01, 43.02, 43.03 and 43.04 .
V.E.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.	Non Compliance **Non Compliance**	The Commonwealth has not met Indicators 44.01 and 44.02. .

Settlement Agreement Reference	Provision	Compliance Rating	Comments
V.F.1.	For individuals receiving case management services pursuant to this Agreement, the individual's case manager shall meet with the individual face-to-face on a regular basis and shall conduct regular visits to the individual's residence, as dictated by the individual's needs.	Sustained Compliance	T*he case management and the ISR study found Compliance with the required frequency of visits. DBHDS reported data that some CSBs are below target.*
V.F.2.	At these face-to-face meetings, the case manager shall: observe the individual and the individual's environment to assess for previously unidentified risks, injuries, needs, or other changes in status; assess the status of previously identified risks, injuries, needs, or other change in status; assess whether the individual's support plan is being implemented appropriately and remains appropriate for the individual; and ascertain whether supports and services are being implemented consistent with the individual's strengths and preferences and in the most integrated setting appropriate to the individual's needs….	Non Compliance Non Compliance	*When Virginia achieves the Indicators for III.C.5.b.i., it also achieve compliance for this Provision.*
V.F.3.a.-f.	Within 12 months of the effective date of this Agreement, the individual's case manager shall meet with the individual face-to-face at least every 30 days, and at least one such visit every two months must be in the individual's place of residence, for any individuals (who meet specific criteria).	Sustained Compliance	*The ninth, twelfth, fourteenth, and sixteenth and eighteenth ISR studies found that the case managers had completed the required monthly visits for 130 of 134 individuals (96.0%).*
V.F.4.	Within 12 months from the effective date of this Agreement, the Commonwealth shall establish a mechanism to collect reliable data from the case managers on the number, type, and frequency of case manager contacts with the individual.	Non Compliance Non Compliance	*The Commonwealth has not met the two Compliance Indicators 46.01 and 46.02, and therefore remains in Non-Compliance.*

Settlement Agreement Reference	Provision	Compliance Rating	Comments
V.F.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 observation and assessments, shall be reported to the Commonwealth for its review and assessment of data. Reported key indicators shall capture information regarding both positive and negative outcomes for both health and safety and community integration and will be selected from the relevant domains listed in V.D.3.	Non Compliance Non Compliance	*The Commonwealth has not met the sole Compliance Indicator 47.01, and therefore remains in Non-Compliance.*
V.F.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.	Sustained Compliance	*The statewide CM training modules have been updated and improved and are consistent with the requirements of this provision.*
V.G.1.	The Commonwealth shall conduct regular, unannounced licensing inspections of community providers serving individuals receiving services under this Agreement.	**Sustained Compliance**	OLS regularly renewed unannounced inspection of community providers.
V.G.2.a.-f.	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 ...	**Sustained Compliance**	OLS has maintained a licensing inspection process with more frequent inspections.
V.G.3.	Within 12 months of the effective date of this Agreement, the Commonwealth shall ensure that the licensure process assesses the adequacy of the individualized supports and services provided to persons receiving services under this Agreement in each of the domains listed in Section V.D.3 above and that these data and assessments are reported to DBHDS.	Non Compliance **Non Compliance**	The Commonwealth met all four Compliance Indicators 48.01, 48.02, 48.03 and 48.04*. The Commonwealth remains in Non-Compliance. *See note at the bottom of the Compliance Table.

Settlement Agreement Reference	Provision	Compliance Rating	Comments
V.H.1.	The Commonwealth shall have a statewide core competency-based training curriculum for all staff who provide services under this Agreement. The training shall include person-centered practices, community integration and self-determination awareness, and required elements of service training.	Non Compliance **Non Compliance**	The Commonwealth has met Compliance Indicators 49.01, 49.05, 49.06, 49.07,49.08, 49.09, 49.10, 49.11, and 49.13. The Commonwealth has not met Indicators 49.02, 49.03, 49.04, and 49.12.
V.H.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.	Compliance **Sustained Compliance**	The Commonwealth met all three Compliance Indicators 50.01, 50.02, and 50.03, and has achieved Compliance for the second consecutive review and therefore has achieved Sustained Compliance.
V.I.1.a.-b.	The Commonwealth shall use Quality Service Reviews ("QSRs") to evaluate the quality of services at an individual, provider, and system-wide level and the extent to which services are provided in the most integrated setting appropriate to individuals' needs and choice.	Non Compliance **Non Compliance**	The Commonwealth's QSRs in 2020 did not meet Indicator 51.04, and therefore remains in Non-Compliance. Its QSRs did not adequately assess whether service recipients were kept safe from harm and whether providers accessed treatment as necessary.
V.I.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. .	Non Compliance **Non Compliance**	The Commonwealth's QSRs in 2020 did not meet Indicator 52.01, and therefore remains in Non-Compliance. It's QSRs did not adequately assess whether individuals' healthcare needs were identified and met or that service plans were modified as needed.
V.I.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.	Non Compliance Non Compliance	*The extent to which the Commonwealth achieved the four Compliance Indicators for this provision were studied during the 17th Review Period*

Settlement Agreement Reference	Provision	Compliance Rating	Comments
V.I.4.	The Commonwealth shall conduct QSRs annually of a statistically significant sample of individuals receiving services under this Agreement.	Sustained Compliance	*The Commonwealth's contractor completed the second annual QSR process based on a statistically significant sample of individuals.*
VI.	**Independent Reviewer**	**Rating** **COMPLIANCE*** designates the portions of the Consent Decree achieved by Virginia and relieved by the Court.	**Comments**
VI.D.	Upon receipt of notification, the Commonwealth shall immediately report to the Independent Reviewer the death or serious injury resulting in ongoing medical care of any former resident of a Training Center. The Independent Reviewer shall forthwith review any such death or injury and report his findings to the Court in a special report, to be filed under seal with copies to the parties. The parties will seek a protective order permitting these reports to be …and shared with Intervener's counsel.	**COMPLIANCE***	DBHDS promptly reports to the IR. The IR, in collaboration with a nurse and independent consultants, completes his review and issues his report to the Court and the Parties. DBHDS has established an internal working group to review and follow-up on the IR's recommendations.
IX.	**Implementation of the Agreement**	**Rating** Ratings prior to the 19th Period are <u>not</u> in bold. Ratings for the 19th Period are in **bold.**	**Comment**

Settlement Agreement Reference	Provision	Compliance Rating	Comments
IX.C.	The Commonwealth shall maintain sufficient records to document that the requirements of this Agreement are being properly implemented …	Non Compliance **Non Compliance**	The Independent Reviewer determined that the Commonwealth did not maintain sufficient records to document proper implementation of the Provisions, including not determining that its data sources are reliable and valid.

**Note*: Since DBHDS has not yet determined that the sources of its data provide reliable and valid information available for compliance reporting, "*met" determinations are not yet final, but rather for illustrative purposes only.

Note: On March 3, 2021, the Court ordered that it found the Commonwealth in compliance with Sections IV. and VI.D. of the Consent Decree and relieved the Commonwealth of those portions of the Consent Decree.

VI. APPENDICES

APPENDIX A

Behavioral Services

By Patrick Heick Ph.D., BCBA-D, LABA

With

Alan Harchik Ph.D., BCBA-D
Matthew Quinby MA, BCBA, LABA
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Nineteenth Review Period Individual Services Review Study:

Individuals with Challenging Behavioral Needs

Submitted By: Patrick Heick, Ph.D., BCBA-D, LABA, Team Leader
Alan Harchik, Ph.D., BCBA-D, LABA
Matthew Quinby, MA, BCBA, LABA
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November 14, 2021

Introduction

This report, including the following *Summary* and *Addendum,* was prepared, and submitted in response to the Independent Reviewer's request for a study, as part of the 19th Review Period, to examine the Commonwealth of Virginia's implementation of the Settlement Agreement (SA) as it pertains to the nature of behavioral supports provided to individuals with challenging behaviors. The current Individual Services Review (ISR) study was designed to specifically examine two Compliance Indicators (CI) under provision V.I.1. – these included:

51.05 The Quality Service Reviews (QSRs) assess on a system-wide level whether:
c. *Providers keep service recipients safe from harm and access treatment for service recipients as necessary.*

52.01 The QSRs assess on an individual service-recipient level and individual provider level whether:
a. *Individuals' needs are identified and met, including health and safety.*

The purpose of the current ISR study was to identify whether or not there are discrepancies between determinations of the Department of Behavioral Health and Disability Services (DBHDS) QSR vendor's non-clinical auditors during the 2020 QSR study and determinations of the four clinically qualified reviewers on the current ISR team. The four reviewers on the ISR team were licensed Board Certified Behavior Analysts (BCBA) with extensive experience in the provision of behavioral services to individuals with significant challenging behaviors in community-based settings. The specific two discrepancies being studied are two overall judgment questions that are required by CI 51.05 and 52.01, as noted above, including (1) were the individuals protected from harm and access treatment as necessary and (2) were the individuals needs identified and met, including health and safety.

Methodology

The following Summary, including findings and related data summaries, is based upon the reviews of a sample of 40 individuals (18 females and 22 males). This sample was randomly selected from a list provided by DBHDS of individuals with Service Eligibility Assessment scores of Level 7 and whose services were evaluated during the DBHDS's 2020 QSR study. The "Support Level 7' scores of these individuals identifies them as having significant risk due to the nature of their challenging behavior. The IRS study utilized a Questionnaire (Attachment 3) to review the individual's status as well as the provision of needed behavioral support services. More specifically, these reviews examined the need for behavioral support as well as the nature of interventions and outcomes associated with each individual's behavioral presentation. Reviews examined the nature of the current behavioral programming and supports reported to be currently (or previously) in place, including whether there was a Functional Behavior Assessment (FBA) and/or Behavior Support Plan (BSP), when it was developed or last updated, the credentials of the professional who developed and/or supervised its implementation, and whether competency-based training of the BSP was completed.

This study's individual services reviews also examined the quality of behavioral programming (FBAs, BSPs) provided for review by using the DBHDS Behavior Support Plan Adherence Review Instrument (BSPARI). The BSPARI examines the minimal requirements of a BSP prescribed within the Practice Guidelines. Due to the lack of standards for behavioral programming for individuals with IDD, the study compared the behavioral programming in place in 2020 to the DBHDS Practice Guidelines minimum standards that were established in July 2021. This aimed to establish a baseline of the status of behavioral services before the implementation of the minimum standards for behavioral programming in the Commonwealth's Practice Guidelines. Lastly, the findings of each ISR review were compared to findings of the QSR study of the same individuals in order to identify any discrepancies with the clinical judgments of non-clinical QSR auditors. It should be noted that the current reviews were based on the understanding that all existing documents were provided in response to the Independent Reviewer's document request.

However, it should also be noted that the documentation provided and reviewed here may be considerably different than the documents available and reviewed by the QSR auditors. DBHDS was not able to ensure that the documents they provided for this ISR study were the same documents that their vendors QSR auditors reviewed.

The following Summary is submitted in addition to the ISR Monitoring Questionnaires that were completed for each individual sampled as well as overall Data Summaries (Attachment 1) and individual scoring comparisons between the QSR auditors and the ISR reviewers on two Compliance Questions, including (1) "Do providers keep service recipients safe from harm?" (Attachment 2, Chart A) and (2) "Are Individuals' needs identified and met?" (Attachment 2, Chart B) for each individual sampled. Although the Commonwealth provided the master list of individuals who DBHDS believed met the criteria for inclusion in this study, the current ISR review found that nine of the forty individuals who were randomly selected had not been evaluated by the QSR auditors in their 2020 QSR study – see Findings section for more details.
First, it should be noted that the completed ISR Monitoring Questionnaires (MQ) were submitted separately and under seal as they include private health information. The following Summary and Data Summaries within the Addenda are based upon these MQs which were completed using information provided during off-site reviews, including review of available documentation provided in response to the Independent Reviewer's document request (Attachment 4) as well as one or more phone calls with residential providers as well as behavior specialists and others, as available, as identified on the contact information request. It should be noted that questions on the MQ referencing whether or not an item (e.g., FBA, BSP) was completed was only endorsed (i.e., 'Yes' or '1') if the actual document was provided for review. It should also be noted that questions on the MQ as well as the BSPARI examining elements of the Functional Behavioral Assessment (FBA) and Behavioral Support Plan (BSP) were answered only using content within the FBA and/or BSP, as provided. In addition, attempts were made by ISR reviewers to restrict scoring of items within Attachment 2 to evidence provided within the last 12 months. It should be noted that the provided documentation reviewed by the ISR reviewers may be considerably different than the documents available and reviewed by the QSR auditors.

Summary

Findings

1. The comprehensive nature of this ISR study was limited, given that comparisons could not be completed on almost one-quarter of the sample as planned. Of the 40 individuals in the sample, only 31 (78%) were identified within the previous QSR study, based on data provided for review (see Figures 1 and 2). More specifically, nine (23%) of the sampled individuals (i.e., Individuals #1, #12, #17, #19, #21, #28, #31, #37, and #40) were not included within the QSR data provided by DBHDS.

2. Of the 31 individuals reviewed, the ISR reviewers identified seven (23%) individuals who were not protected from harm; whereas the QSR auditors identified (see Figure 1) only one (14%) of the seven individuals in its 2020 study. As previously noted, this study examined the correspondence of answers between QSR auditors and ISR reviewers in determining adherence to Compliance Indicator 51.05 regarding whether or not individuals were protected from harm and accessed treatment as necessary. Overall, the ISR study found that agreement on scores recorded by the QSR auditors and the ISR reviewers across all sampled individuals was only 76% (i.e., this percentage does not include scores of "CND" for two individuals). Both the QSR auditors and the ISR reviewers recorded similar scores for 22 (76%) of the 29 individuals who received scores of "Yes" (1) or "No" (0). It should be noted that the ISR Reviewers scored "CND" for two individuals due to the lack of current and/or compelling documented evidence. Of the 31 individuals included in the QSR study, the ISR reviewers found: (1) that 22 (71%) individuals were protected from harm and accessed treatment as necessary and (2) that seven individuals were not protected from harm and accessing treatment as necessary (i.e., Individuals #4, #6, #7, #13, #24, #33 and #39) – for more specification, see Attachment 2 (Chart A). Of the 31 individuals identified in the QSR study, the QSR auditors recorded that 29 (94%) were protected from harm and accessed treatment as necessary. The QSR auditors identified two individuals as not protected from harm and accessing treatment as necessary (i.e., Individuals #6 and #29.) Although the QSR auditors and ISR reviewers recorded similar scores for one of the individuals (i.e., #6), the scores

differed for the second individual (#29). According to comments found within the provided QSR data (i.e., for Individual #29), during the QSR study, the Auditor described that the individual experienced a peer-to-peer rights violation that involved Adult Protective Services (APS), a threat to his life and aggression. In addition, the Auditor noted that, although the ISP was not updated, the team did meet to discuss the situation one month later. The current ISR Reviewer did not identify this issue within the documentation provided for review and the issue was not voiced by the informant during the interview. Note: With regard to Figure 1 and Attachment 2 (Chart A), the ISR reviewer estimated the score (either 'Yes' or "No') to the "QSR – protect from harm" and "QSR auditor answered" item, respectively, for each sampled individual using the score (either 'Yes' or "No") recorded under the column title "*Is there any evidence of actual or potential harm, including neglect*" noted within the QSR data provided for review.

3. This ISR study by qualified clinicians determined that there was a discrepancy rate of 87% between its findings that 28 individuals did not have their behavioral services needs met compared with the QSR auditors without clinical qualifications who determined that 30 of the 31 individuals did have their behavioral service needs met. Of the 31 individuals reviewed, the ISR reviewers identified twenty-eight (90%) individuals whose needs were not identified and met, including health and safety; whereas the QSR auditors (see Figure 2) identified only one (4%) of the twenty-eight individuals. As previously noted, this study examined the correspondence of answers regarding whether or not individuals' needs were identified and met between QSR auditors and ISR reviewers in determining adherence to Compliance Indicator 52.01. Overall, the ISR study found that agreement on scores recorded regarding whether individuals needs were met by QSR auditors and ISR reviewers across all sampled individuals was only 13%. That is, both the QSR auditors and the ISR reviewers recorded similar scores for four (13%) of the 31 individuals. The ISR reviewers identified three (10%) individuals who had their needs identified and met (i.e., Individuals #11, #15, and #16) – for more specification, see Attachment 2 (Chart B). Of the 31 individuals identified in the QSR study, the QSR auditors recorded that 30 (97%) had their needs identified and met, including health and safety. The QSR auditors identified one individual (#35) who did not have their needs identified and met; this was consistent with the finding of the ISR study. Note: With regard to Figure 2 and Attachment 2 (Chart B), the ISR reviewer estimated the score (either 'Yes' or "No') to the item "QSR – needs met?" and "QSR auditor answered" item,

respectively, for each sampled individual using the score (either 'Yes' or "No") recorded under the column title "*Review of service provision validated that needs are met*" noted within the QSR data provided for review.

4. This study concluded that the majority of the individuals sampled would likely benefit from behavioral programming or other therapeutic supports. This conclusion is based on a review of the completed individuals' service records and other provided documentation as well as the completed ISR Monitoring Questionnaires. In general, nearly all of the individuals sampled demonstrated maladaptive behaviors that had unsafe and/or disruptive consequences to themselves and their households, including negative impacts on their ability to access their communities, to learn new skills, to become more independent and/or to improve the quality of their lives. Meeting these criteria is a strong indication that these individuals would likely benefit from formal behavioral programming (or other therapeutic supports) implemented within their homes or residential programs. More specifically, of those sampled, 40 (100%) engaged in behaviors that could result in injury to self or others, 40 (100%) engaged in behaviors that disrupt the environment, and 31(78%) engaged in behaviors that impeded his or her ability to access a wide range of environments (see Figure 3). In addition, of those sampled, 30 (75%) engaged in behaviors that impeded their ability to learn new skills or generalize already learned skills. Overall, 38 (95%) of the individuals sampled appeared to demonstrate significant maladaptive behaviors that negatively impacted their quality of life and greater independence.

5. The ISR study found that of the 40 individuals sampled, only 17 (43%) had BSPs currently in place. Of the 23 individuals without BSPs currently implemented, Individual Support Plans (ISPs) for 10 (43%) indicated that a BSP was needed. This finding as well as the level of need reported for the majority of sampled individuals, as evidenced by the scores on items 1 though 5 in Section 2 of the MQ (see Figure 3), does not reflect an adequate provision of behavioral support. Although the study found that the majority of sampled individuals would likely benefit from behavioral programming or other therapeutic supports given their identified needs, of those sampled, only 27 (68%) individuals had received and/or were currently receiving behavioral programming through the implementation of comprehensive BSPs in their homes (see Figure 4). And, as noted above, even fewer (43%) individuals had BSPs implemented at the time of the ISR study. NOTE: After

the ISR study was completed, the Commonwealth reported that two individuals (Individual #14 and #28) had BSPs that were not reflected in the current findings. The BSP for Individual #14 was not reviewed as it was last implemented in 2016 at a previous residential setting and prior to being incarcerated for two years. In addition, reports indicated that no BSP had ever been implemented within his current residential setting since his admission in 2019. Indeed, verbal report from Individual #14 indicated that a BSP was not wanted. Nonetheless, the decision to not review these BSPs underestimates the reported number of BSPs previously implemented for the 40 individuals sampled. In addition, the Commonwealth reported that one Individual #19 had an FBA integrated into the body of a BSP for individual #19. Overall, these BSPs and FBA are not reflected in the current consultants' findings.

6. As noted above, of the 40 individuals sampled, 27 (68%) individuals had BSPs that were previously and/or currently in place. Evidence indicated that 26 (96%) were developed either by a Positive Behavior Support Facilitator (PBSF) or a Board Certified Behavior Analyst (BCBA)[1] – it was noted that BCBAs completed 16 (59%) of the BSPs (see Figure 5). In addition, of the 27 individuals with BSPs, 26 (96%) had evidence of a Functional Behavior Assessment (FBA). DBHDS Practice Guidelines for Behavior Support Plans identified the completion of an FBA as a required minimum element when developing a BSP. Consequently, not completing an FBA, as evident for one of the individuals reviewed (i.e., Individual #19), reflected nonadherence to the Practice Guidelines. Overall, evidence indicated that only 23 (88%) of the FBAs were developed by a PBSF or BCBA – it was noted that BCBAs completed 15 (58%) of the FBAs.

7. The ISR study reviewed 27 BSPs using the DBHDS BSPAIR, only one (4%) of the BSPs was adequate in its adherence to the inclusion of minimum content areas and related minimum elements. The BSP for #11 had a score of 34 or higher (see Figure 6). As previously noted, DBHDS recently created the BSPARI to examine adherence of BSPs with regard to the inclusion of minimum elements prescribed by the Practice Guidelines for BSPs. According to the scoring

[1] The BCBA is the nationally accepted certification for practitioners of applied behavior analysis. This certification is granted by the Behavior Analyst Certification Board (BACB), a nonprofit corporation established to develop, promote, and implement a national and international certification program for behavior analyst practitioners. In Virginia, the PBSF is an endorsement given to practitioners who have completed DBHDS/VCU sponsored training in positive behavior support.

instructions, a BSP is deemed to be adequate in its adherence to the inclusion of minimum content areas and related minimum elements if it scores at least 34 out of 40 points. This ISR study utilized the BSPARI to examine the BSPs provided in an effort to evaluate their adherence to the Practice Guidelines.

8. Evidence that care providers had successfully completed competency-based training on the BSP was provided for seven (26%) of the 27 individuals with BSPs (see Figure 7). Minimum elements prescribed within the DBHDS Practice Guidelines included behavior skills training as well as documentation of care provider training on the BSP. In addition, evidence that data on all target behaviors (for decrease) and functionally equivalent replacement behaviors (i.e., target behaviors for increase) had been adequately summarized and regularly reviewed was not found for any of the individuals reviewed.

Conclusions – Primary Areas of Concern:

1. The comprehensive nature of the review was limited as nearly one-quarter of the sample was not identified within the previous QSR data.

2. The ISR study found a discrepancy rate of approximately 24%. When examining adherence to Compliance Indicator 51.05, the ISR reviewers identified seven of the 31 individuals who were not protected from harm and accessing treatment as necessary. The QSR auditors identified only one of these seven individuals.

3. When examining adherence to Compliance Indicator 52.01, ISR reviewers identified 28 individuals who did not have their needs identified and met, including health and safety. Whereas the QSR auditors identified only one individual of these 28 individuals as not having their needs identified and met. Overall, agreement on scores recorded by the QSR auditors and the ISR reviewers across all sampled individuals was low (13%).

4. The ISR's clinical reviewers found that a substantial percentage of individuals in the sample who needed access to behavioral programming were not currently receiving necessary behavioral supports and services. Although the ISR study found that a majority of individuals were likely to benefit from behavioral programming or other supports, less than half of the individuals sampled had BSPs currently in place. Indeed, of the 23 individuals without BSPs currently implemented, individual support plans for 10 (43%) indicated that a BSP was needed. Consequently, given that the majority of individuals who demonstrated a need for formal behavioral programming and the number of BSPs currently implemented, many were not receiving needed support services.

5. The majority of behavioral programming being provided to the individuals in the sample did not meet the standards prescribed within the DBHDS Practice Guidelines. This conclusion was based on examination of the BSPs using the BSPARI, nearly all of the BSPs were found to be inadequate. More specifically, only one BSP received a score of 34 or higher indicating that, based on the BSPARI scoring instructions guide, all of the minimum content areas and related minimum elements were included.

6. Evidence of adequate training of the BSP with care providers was provided for just over one-quarter of the individuals with BSPs. Evidence of adequate data collection of behaviors for increase (functionally equivalent behaviors) and decrease as well as regular review was not provided for any of the individuals sampled.

7. The majority of individuals sampled demonstrated unsafe behavior that placed themselves and/or others at risk. In addition, most individuals displayed disruptive and/or other behaviors that limited their ability to access diverse community settings and their ability to learn new skills. Overall, the majority of individuals engaged in behaviors that negatively impacted their quality of life and greater independence.

Respectfully submitted by,

Patrick F. Heick, Ph.D., BCBA-D, LABA
Manager, PFH Consulting, LLC

Attachment 1
Data Summaries, including Figures 1 – 7 below:
Key for Figures 1 – 7: 0 = No, 1 = Yes

Figure 1		QSR	ISR	QSR & ISR
ID #	Identified in QSR study?	protect from harm?	protect from harm?	agreement
#1	0			
#2	1	1	1	1
#3	1	1	1	1
#4	1	1	0	0
#5	1	1	1	1
#6	1	0	0	1
#7	1	1	0	0
#8	1	1	1	1
#9	1	1	1	1
#10	1	1	1	1
#11	1	1	1	1
#12	0			
#13	1	1	0	0
#14	1	1	CND	
#15	1	1	1	1
#16	1	1	1	1
#17	0			
#18	1	1	1	1
#19	0			
#20	1	1	CND	
#21	0			
#22	1	1	1	1
#23	1	1	1	1
#24	1	1	0	0
#25	1	1	1	1
#26	1	1	1	1
#27	1	1	1	1
#28	0			
#29	1	0	1	0
#30	1	1	1	1
#31	0			
#32	1	1	1	1
#33	1	1	0	0
#34	1	1	1	1
#35	1	1	1	1
#36	1	1	1	1
#37	0			
#38	1	1	1	1
#39	1	1	0	0
#40	0			
total (N=40)	31	29	22	22
percentage	78%	94%	71%	76%
Key: 0 = No; 1 = Yes				

Figure 2		QSR	ISR	QSR & ISR
ID #	Identified in QSR study?	needs met?	needs met?	agreement
#1	0			
#2	1	1	0	0
#3	1	1	0	0
#4	1	1	0	0
#5	1	1	0	0
#6	1	1	0	0
#7	1	1	0	0
#8	1	1	0	0
#9	1	1	0	0
#10	1	1	0	0
#11	1	1	1	1
#12	0			
#13	1	1	0	0
#14	1	1	0	0
#15	1	1	1	1
#16	1	1	1	1
#17	0			
#18	1	1	0	0
#19	0			
#20	1	1	0	0
#21	0			
#22	1	1	0	0
#23	1	1	0	0
#24	1	1	0	0
#25	1	1	0	0
#26	1	1	0	0
#27	1	1	0	0
#28	0			
#29	1	1	0	0
#30	1	1	0	0
#31	0			
#32	1	1	0	0
#33	1	1	0	0
#34	1	1	0	0
#35	1	0	0	1
#36	1	1	0	0
#37	0			
#38	1	1	0	0
#39	1	1	0	0
#40	0			
total (N=40)	31	30	3	4
percentage	78%	97%	10%	13%

Figure 3	**MQ Item #1**	**MQ Item #2**	**MQ Item #3**	**MQ Item #4**	**MQ Item #5**
ID #	*Injury to self or others*	*Disruptive behavior*	*Behavior impedes access*	*Behavior impedes learning*	*Behavior impacts QOL*
#8	1	1	1	1	1
#15	1	1	1	1	1
#32	1	1	1	1	1
#35	1	1	1	1	1
#36	1	1	1	1	1
#7	1	1	0	0	1
#11	1	1	1	1	1
#17	1	1	1	1	1
#18	1	1	1	1	1
#21	1	1	1	1	1
#22	1	1	1	1	1
#26	1	1	1	1	1
#29	1	1	0	0	1
#6	1	1	1	1	1
#12	1	1	1	0	1
#16	1	1	1	0	1
#23	1	1	1	1	1
#38	1	1	1	1	1
#1	1	1	1	1	1
#2	1	1	1	1	1
#4	1	1	1	1	1
#9	1	1	1	1	1
#13	1	1	0	0	1
#19	1	1	0	1	1
#20	1	1	1	0	1
#24	1	1	0	1	1
#28	1	1	1	1	1
#33	1	1	1	1	1
#34	1	1	1	1	1
#37	1	1	1	0	1
#39	1	1	0	0	1
#3	1	1	1	1	1
#5	1	1	1	1	1
#10	1	1	1	1	1
#14	1	1	1	1	1
#25	1	1	0	0	0
#27	1	1	0	1	1
#30	1	1	1	1	1
#31	1	1	1	1	1
#40	1	1	0	0	0
total (N=40)	40	40	31	30	38
percentage	100%	100%	78%	75%	95%

Figure 4			
ID #	BSP Reviewed	BSP Currently in Place	ISP Recommends BSP
#8	1	0	1
#15	1	0	0
#32	1	1	
#35	1	0	1
#36	0		1
#7	1	1	
#11	1	1	
#17	1	1	
#18	1	1	
#21	1	1	
#22	1	1	
#26	1	1	
#29	1	1	
#6	1	1	
#12	0		0
#16	0		0
#23	0		0
#38	0		0
#1	1	1	
#2	1	0	1
#4	1	0	1
#9	1	1	
#13	0		0
#19	1	1	
#20	0		1
#24	1	0	0
#28	0		1
#33	1	1	
#34	0		0
#37	0		1
#39	1	1	
#3	0		0
#5	1	0	1
#10	1	0	0
#14	0		0
#25	1	0	1
#27	1	1	
#30	1	1	
#31	0		0
#40	1	0	0
total (N=40)	27	17	10
percentage	68%	43%	43%

Figure 5						
ID #	BSP Reviewed	BSP Completed by BCBA/PBSF	BSP Completed by BCBA	FBA completed	FBA Completed by BCBA/PBSF	FBA Completed by BCBA
#8	1	1	1	1	1	1
#15	1	1	1	1	1	1
#32	1	1	1	1	1	1
#35	1	1	0	1	0	0
#36	0					
#7	1	1	1	1	1	1
#11	1	1	1	1	1	1
#17	1	1	1	1	1	1
#18	1	1	1	1	1	1
#21	1	1	1	1	1	1
#22	1	1	1	1	1	1
#26	1	1	1	1	1	1
#29	1	1	1	1	1	1
#6	1	0	0	1	0	0
#12	0					
#16	0					
#23	0					
#38	0					
#1	1	1	0	1	0	0
#2	1	1	1	1	1	1
#4	1	1	1	1	1	1
#9	1	1	1	1	1	1
#13	0					
#19	1	1	1	0		
#20	0					
#24	1	1	0	1	1	0
#28	0					
#33	1	1	1	1	1	1
#34	0					
#37	0					
#39	1	1	0	1	1	0
#3	0					
#5	1	1	0	1	1	0
#10	1	1	0	1	1	0
#14	0					
#25	1	1	0	1	1	0
#27	1	1	0	1	1	0
#30	1	1	0	1	1	0
#31	0					
#40	1	1	0	1	1	0
total (N=40)	27	26	16	26	23	15
percentage	68%	96%	59%	96%	88%	58%

Figure 6		
ID #	BSPARI Score	34 pts or more
#8	13	0
#15	19	0
#32	18	0
#35	16	0
#7	17	0
#11	34	1
#17	20	0
#18	21	0
#21	19	0
#22	26	0
#26	23	0
#29	28	0
#6	7	0
#1	14	0
#2	18	0
#4	15	0
#9	23	0
#19	13	0
#24	6	0
#33	23	0
#39	13	0
#5	21	0
#10	3	0
#25	10	0
#27	25	0
#30	31	0
#40	20	0
total (N=27)		1
percentage		4%
Key: 0 = No; 1 = Yes		

Figure 7		
ID #	**Training**	**Data**
#8	0	0
#15	0	0
#32	1	0
#35	0	0
#7	1	0
#11	0	0
#17	1	0
#18	1	0
#21	0	0
#22	1	0
#26	1	0
#29	0	0
#6	0	0
#1	0	0
#2	0	0
#4	0	0
#9	0	0
#19	0	0
#24	0	0
#33	0	0
#39	0	0
#5	0	0
#10	0	0
#25	0	0
#27	0	0
#30	0	0
#40	0	0
total (N=27)	6	0
percentage	22%	0%

ATTACHMENT 2
CHART A

Name	**Compliance Question: *Do providers keep service recipients safe from harm?***	**Response**
#1	This individual was not included in the QSR study.	
#2	QSR Auditor answered ISR Reviewer answered Issue identified, if ISR Reviewer answered No:	Yes ☒ No ☐ Yes ☒ No ☐
#3	QSR Auditor answered ISR Reviewer answered Issue identified, if ISR Reviewer answered No:	Yes ☒ No ☐ Yes ☒ No ☐
#4	QSR Auditor answered ISR Reviewer answered Issue identified, if ISR Reviewer answered No: The BSP reviewed is not currently in place. Supervision is documented as 1:1, however, verbal reports indicate he is no longer supervised as a 1:1. The reviewed BSP does not address medication refusal or emotional outbursts, supervision in community settings, supervision in the van, suicidal attempts, or suicidal statements. Although the reviewed documentation and verbal reports indicated that he required significant medical intervention due to his pica behavior, this was not addressed within the provided BSP. The BSP provided for review was determined to be inadequate given that it did not include minimal elements as prescribed within the Practice Guidelines. This includes but is not limited to: ISP Update 10/26/20 indicates crisis plan, Behavior Support Plan, that he works with behavior specialist, occupational therapist, counselor, and REACH. The BSP (2021) document is absent of any crisis plan or instructions on where to find it. It is this reviewer's opinion that a crisis plan is needed for suicide attempts, aggression, pica, and other severely harmful behaviors that have the potential to occur. The FBA document did not include all minimal	Yes ☒ No ☐ Yes ☐ No ☒

	elements; therefore, it is unlikely that the FBA document adequately informed the development of the BSP. At the time of the interview, the residential provider indicated that the behavioral provider had discharged the individual on or about summer 2021, and that no formal professional behavioral services are occurring at the time of the interview. During the interview, the residential provider described a severe incident where the individual attacked his housemate and required a physical restraint in summer 2021. Staff were able to treat the housemate with first aid, per verbal report of the residential provider. No other details on the injuries were provided. SIS document (1/31/20) describes medication refusal and elopement occurring weekly, aggression, including kicking, pushing, punching, throwing things at others, occurs monthly. Pica includes swallowing tacks, glass, staples, screws, batteries, and other small objects, and occurs 2-3 times per month. He has been hospitalized several times for ingesting these items in the recent past, exact timing is not indicated. Self-Injury includes the insertion of objects into his anus, cutting himself, ingesting cleaning chemicals, and occurs 1-2 times weekly. ISP indicates that "*(Individual) has scarring and permanent damage from inserting objects into his anus, that has resulted in hemorrhoids and current constipation management.*" Physical intervention or calling police (911) is indicated.	
#5	QSR Auditor answered ISR Reviewer answered Issue identified, if ISR Reviewer answered No:	Yes ☒ No ☐ Yes ☒ No ☐
#6	QSR Auditor answered ISR Reviewer answered Issue identified, if ISR Reviewer answered No: The individual has a history of extreme assaultive behavior and, as a result, has experienced conviction (e.g., including several misdemeanor assaults), incarceration and probation. Per the recent Part V: Plan for Supports - Summary (dated 4/1/21 – 3/31/22), she was currently on probation after recently spending time in jail for assaulting staff. Per the current ISP (dated 4/1/21 – 3/31/22), she has been in psychiatric hospitals	Yes ☐ No ☒ Yes ☐ No ☒

	most often because of her behaviors, including attacks on others (dates of admissions were not provided and could not be verified). Reports indicated prior use of physical restraint (dates could not be verified) as well as the current use of restrictive interventions (e.g., limited and monitored access to use of the phone, computer, and electronic devices as well as video cameras) and 2:1 staffing in the community. The BSP provided for review was determined to be inadequate given that it did not include minimal elements as prescribed within the Practice Guidelines. The BSP was not developed by a Licensed Behavior Analyst or Positive Behavior Support Facilitator. In addition, evidence of adequate ongoing data collection (including targets for increase and decrease) and review was not provided.	
#7	QSR Auditor answered ISR Reviewer answered Issue identified, if ISR Reviewer answered No: This individual has a history of inappropriate sexual behavior that includes inappropriate touching, public masturbation, soliciting sex from peers, and group masturbation. The ISP (dated 6/1/21-5/31/22) indicates that this behavior problem occurred within the previous ISP year and that incidents included "sexual aggression" in the form of touching and soliciting his housemate for sex. The ISP also indicates that there is a formal behavioral support plan in place that provides support for the prevention of "non-aggressive but inappropriate sexual behavior". The Part V: Therapeutic Consultation (dated 6/1/21-5/31/22) also indicates that the individual needs to be supported for the prevention of nonaggressive but inappropriate sexual behavior. The completed FBA (dated 5/26/20) indicates that this individual was referred for Therapeutic Consultation due to aggression, property destruction, and unwelcome sexual behavior. However, the FBA only specifically targets physical aggression and property destruction for evaluation. The Behavior Intervention Plan (not dated) indicates that inappropriate sexual behaviors "interferes with the effective and efficient implementation of the individual's service plan" but does not specifically target or provide any direction for staff on how to manage, decrease, or avoid this behavior. Given that this individuals housemate has been subjected to inappropriate touching and has been solicited by this individual for sex, it appears that this housemate may continue to be	Yes ☒ No ☐ Yes ☐ No ☒

	exposed to further sexual assault without necessary intervention and supervision.	
#8	QSR Auditor answered ISR Reviewer answered Issue identified, if ISR Reviewer answered No:	Yes ☒ No ☐ Yes ☒ No ☐
#9	QSR Auditor answered ISR Reviewer answered Issue identified, if ISR Reviewer answered No:	Yes ☒ No ☐ Yes ☒ No ☐
#10	QSR Auditor answered ISR Reviewer answered Issue identified, if ISR Reviewer answered No:	Yes ☒ No ☐ Yes ☒ No ☐
#11	QSR Auditor answered ISR Reviewer answered Issue identified, if ISR Reviewer answered No:	Yes ☒ No ☐ Yes ☒ No ☐
#12	This individual was not included in the QSR study.	
#13	QSR Auditor answered ISR Reviewer answered Issue identified, if ISR Reviewer answered No: The individual will engage in SIB about once per week; this includes scratching her forearm, digging into her skin with her nails, pulling her breast area, rocking back and forth to cause a bruise, then saying "look" (she will want to show staff the bruise). She rubs up against the furniture to put a "rug burn" or bruise on herself. She will instigate other drivers by sticking her middle finger up, which has angered other drivers in the past, presenting potential for vehicle accidents and injury. She will also wander away from staff in the community.	Yes ☒ No ☐ Yes ☐ No ☒

	Quarterly report (1/1/21 – 3/31/21) indicates "limited or no progress" on four goals. It is troubling that for all the desired outcome descriptions, it is indicated for 100% of the line items, that "No, a plan change is not needed," even though the report itself states that there is limited or no progress and the notes state the individual is still harming herself and others. Quarterly report (4/1/21 – 6/30/21) does not indicate any rating for progress on goals. Questions 1-5 at the bottom of the Quarterly report are blank, except for "no changes to the plan needed" is marked, even though the report itself states that there is limited or no progress and the notes state the individual is still harming herself and others. There was no FBA, nor BSP completed. Behavioral Services were not in place at the time of the interview.	
#14	QSR Auditor answered ISR Reviewer answered Issue identified, if ISR Reviewer answered No: "Could Not Determine (CND)" was scored given insufficient data and information, with the exception of anecdotal reports. However, serious concerns were still noted. It was noted that the individual continues to exhibit problem behaviors and remains at risk for injury, hospitalization, and incarceration. Unfortunately, there were no data available, only anecdotal reports. For instance, during the interview, the ISR Reviewer was told that the frequency of occurrence waxes and wanes. That is, the individual can go for one or two months with no problems at all, but at other times can have problem behaviors every day for a week or more. There is no behavior plan in place, and there are no behavioral services in place. During the interview, the owner and manager of his residential program reported occurrences of extreme physical aggression with assaults to staff and to peers. In addition, a recent incident was described where he was throwing rocks at cars passing on the street. The police were called, and he calmed down without further police intervention. Moments that might escalate occur almost every day. Fortunately, he has a stable long-term staff team who can re-direct and talk him through moments that could turn in to aggression, but ultimately don't due to their intervention.	Yes ☒ No ☐ Yes ☐ No ☐ CND ☒

#15	QSR Auditor answered ISR Reviewer answered Issue identified, if ISR Reviewer answered No:	Yes ☒ No ☐ Yes ☒ No ☐
#16	QSR Auditor answered ISR Reviewer answered Issue identified, if ISR Reviewer answered No:	Yes ☒ No ☐ Yes ☒ No ☐
#17	This individual was not included in the QSR study.	
#18	QSR Auditor answered ISR Reviewer answered Issue identified, if ISR Reviewer answered No:	Yes ☒ No ☐ Yes ☒ No ☐
#19	This individual was not included in the QSR study.	
#20	QSR Auditor answered ISR Reviewer answered Issue identified, if ISR Reviewer answered No: "Could Not Determine (CND)" was scored given insufficient data and information as well as a recent improvement following a change in residential placement. However, serious concerns were still noted. Per the PBSF's Status Summary on 8/30/21, shortly following 6/21, the individual had a series of incidents of aggression that led to her sudden arrest, then removal from the home (previous provider), transfer to REACH, and then to (current provider) on 7/9/21. Verbal reports indicate SIB is very concerning and includes when she pinches herself, bites herself, punches herself, pulls her own hair out, picks her skin, pinches her skin, pulls her toenails and fingernails off, she will head-butt walls, swallow objects, self-choke. The provider estimates that these behaviors happen from	Yes ☒ No ☐ Yes ☐ No ☐ CND ☒

	several times per week, to a frequency as high as every other day. In her past, she has assaulted police officers, she ran away from another group home and was gone for between 1-3 months, used drugs, had unprotected sex, went off her medications, and she was on the news. Prior to (previous residential provider), she was in jail for 5-days after hitting and assaulting housemates. She is currently staffed with a 2:1 ratio, and previously she was staffed with a 1:1 ratio. It is reported that she needs very close monitoring to maintain her safety and the safety of those around her. She lives in a home with sharps and chemicals locked, alarms on the windows and doors, child locks engaged in the van with the individual seated in the back with staff beside her, all to prevent dangerous behavior. Verbal reports indicate that the 2:1 staffing ratio is effective at blocking or preventing self-harm. Although there have been no medical hospitalizations due to challenging behavior, it was verbally reported that she occasionally needs first aid from group home staff due to her self-injurious behaviors. Verbal reports from the provider also indicate that she was admitted for two psychiatric hospitalizations in 2021 for about 4-5 days each admission. This reviewer has insufficient information to determine if the individual is experiencing holds against her active resistance. Part V (6/1/21 – 5/31/22) indicates TOVA restraint curriculum as part of her supports. This document also indicates that one of her interventions is for staff to "hold hands" with her to prevent SIB. The owner noted that *she does not need to be restrained often*, and he describes that he *holds her hands when she is upset, that staff sit next to her to prevent injury*. It is described that the hand holding is *soothing to her.* The owner notes that she has not had a hold since she moved into her current home (7/9/21). However, the way he was describing the *hand holding*, it sounded vague to this reviewer whether he considered holding her hands a restraint. This reviewer was unable to garner clarification of this item from the Owner, to identify if the hand holding was against her active resistance. The documents reviewed did not indicate occurrence of restraint. Overall, it is likely that this individual is experiencing a better quality of life, however, she had only just moved in with the current provider fewer than 3 months before the interview. It was clear to this reviewer that the owner knew the individual	

	very well, and cared about providing the best services for her, based on the verbal interview.	
#21	This individual was not included in the QSR study.	
#22	QSR Auditor answered ISR Reviewer answered Issue identified, if ISR Reviewer answered No:	Yes ☒ No ☐ Yes ☒ No ☐
#23	QSR Auditor answered ISR Reviewer answered Issue identified, if ISR Reviewer answered No:	Yes ☒ No ☐ Yes ☒ No ☐
#24	QSR Auditor answered ISR Reviewer answered Issue identified, if ISR Reviewer answered No: The individual is currently engaging in harmful, potentially lethal, problematic behaviors resulting in negative outcomes. For example, the onsite visit tool (OSVT) dated June 2021 indicates a severely dangerous situation where her challenging behavior in the van caused an accident. No documentation of ER or law enforcement involvement. Verbal reports indicate that she and one of her housemates were arguing in the van. The staff was turning on to a different street when she unbuckled her seat belt and tried to fight with the other individual in the van, causing the staff to pull over quickly. In the process of pulling over, the driver hit a small tree. Another example is noted in her SIS dated 9/3/20: in the past she found razor blades and cord, hid these in her room, and used them to attempt suicide. The individual is reportedly currently sending mature photos through social media, engaging with strangers online, responding to strangers' invitations, and sharing personal information with strangers such as her residential home address. She will run away from her residence, and run to the Residential Owner's own home, which is close in proximity to	Yes ☒ No ☐ Yes ☐ No ☒

	the group home residence, and wait for her at the door, unsupervised. There are currently no formal behavioral services in place by a BCBA, or a PBSF. The case management OSVT tools reviewed indicate "N/A" to the question of Behavioral Supports Available and occurring as needed as authorized. These OSVT tools also indicate YES, that all services are implemented appropriately, even though the FBA was over 2 years out of date and written for the individual's previous placement.	
#25	QSR Auditor answered ISR Reviewer answered Issue identified, if ISR Reviewer answered No:	Yes ☒ No ☐ Yes ☒ No ☐
#26	QSR Auditor answered ISR Reviewer answered Issue identified, if ISR Reviewer answered No:	Yes ☒ No ☐ Yes ☒ No ☐
#27	QSR Auditor answered ISR Reviewer answered Issue identified, if ISR Reviewer answered No:	Yes ☒ No ☐ Yes ☒ No ☐
#28	This individual was not included in the QSR study.	
#29	QSR Auditor answered ISR Reviewer answered Issue identified, if ISR Reviewer answered No: Note: According to comments found within the provided QSR data, during the prior QSR study, the Auditor described that the individual experienced a peer-to-peer rights violation that involved APS, a threat to his life, and aggression. In addition, the Auditor noted that, although the ISP was not updated, the team did meet to discuss the situation one month later. The	Yes ☐ No ☒ Yes ☒ No ☐

	current ISR Reviewer did not identify this issue within the documentation provided for review and the issue was not voiced by the informant during the interview.	
#30	QSR Auditor answered ISR Reviewer answered Issue identified, if ISR Reviewer answered No:	Yes ☒ No ☐ Yes ☒ No ☐
#31	This individual was not included in the QSR study.	
#32	QSR Auditor answered ISR Reviewer answered Issue identified, if ISR Reviewer answered No:	Yes ☒ No ☐ Yes ☒ No ☐
#33	QSR Auditor answered ISR Reviewer answered Issue identified, if ISR Reviewer answered No: The provider, who supported the individual for 21-months, estimated that this individual experienced 50 ER visits regarding his blood pressure (due to refusal to eat), and his fistula (he tried to pull it out). The provider estimated that 85% of these ER visits were "behavior based", meaning that his blood pressure was dangerously low due to his refusal to eat. This individual engaged in significant and on-going hospital-seeking behavior that was harmful to himself. The provider reported his perspective/opinion that this individual engages in self-harm to be sent to the hospital, "he has "*made many attempts to stab himself, pulled his fistula out of his arm, pulled his port out of his vein, scratched at his port in attempts to cause it to bleed, refused to eat, and manipulated his blood pressure, all in order to get transported to the hospital."* The provider estimated that the individual engages in these behaviors about every 3 months in a pattern. *The provider explained that when the individual returns home from a hospital or incarceration stays, that the first month he maintains mostly safe behavior, the second month he engages in slightly more self-injury, and the third month is described as the individual needing "almost constant" blocking or re-direction from self-injury.*	Yes ☒ No ☐ Yes ☐ No ☒

	Verbal reports described "*minute to minute re-direction is needed to prevent harmful behaviors*." The providers described a "*cycle to incarceration.*" They observe harmful behaviors almost every hour, REACH is called, the Case Manager is called, property destruction begins, elopement occurs, then the last problem behavior in this pattern is for him to stop eating. When his blood pressure is too low, the individual will be transported to the hospital. Documentation across dates 6/21 – 8/21, indicates 5 mental health check-ins, described as lasting 3 hours or less. *Check-ins were described as visits to the hospital for a crisis evaluation.* The provider's verbal reports indicate a discrepancy, i.e., these "check-ins" across the summer of 2021 are under-documented. Provider indicates that in the month of August 2021 he visited the ER "*about every day*," and REACH came out to visit him at least 4 or 5 times in August 2021. Then, on 8/15/2021, he was incarcerated. The case manager's On Site Visit Tool (dated 07/12/21) describes that the individual was restrained by police during a hospital visit due to threatening behavior and aggression. Verbal reports indicate that he was restrained one time by residential staff in August 2021 due to assault, breaking the chandelier, breaking the TV; altogether a very dangerous and high severity situation. BSP (dated 5/12/21) indicates physical restraint as an intervention when the individual presents a danger to himself or others when at the dialysis center. The BSP provided for review was determined to be inadequate given that it did not include minimal elements as prescribed within the Practice Guidelines, including but not limited to inadequate information for Behaviors Targeted for Decrease, Behaviors Targeted for Increase, Plan for Training, and Decision-Making Documentation. Also missing from the BSP was a detailed crisis plan with instructions for staff reactions, documentation, and restraint release criteria.	
#34	QSR Auditor answered ISR Reviewer answered Issue identified, if ISR Reviewer answered No:	Yes ☒ No ☐ Yes ☒ No ☐
#35	QSR Auditor answered	Yes ☒ No ☐

	ISR Reviewer answered Issue identified, if ISR Reviewer answered No:	Yes ☒ No ☐
#36	QSR Auditor answered ISR Reviewer answered Issue identified, if ISR Reviewer answered No:	Yes ☒ No ☐ Yes ☒ No ☐
#37	This individual was not included in the QSR study.	
#38	QSR Auditor answered ISR Reviewer answered Issue identified, if ISR Reviewer answered No:	Yes ☒ No ☐ Yes ☒ No ☐
#39	QSR Auditor answered ISR Reviewer answered Issue identified, if ISR Reviewer answered No: The individual's set of support services were not keeping her safe. The individual was hospitalized four times in the five months leading up to this ISR Review. One of the individual's problem behaviors is to seek out hospitalization. The problem behaviors that lead to hospitalization are physical aggression (sometimes to police officers) and running away from the group home (often for days at a time). At the time of the ISR Reviewer interview, the individual had (one week before) been transferred from the group home to an adult foster care arrangement in part, because she could not be kept safe at the group home. Although a BSP was implemented, it was not determined to be adequate following examination using the BSPARI. In addition, there was no evidence of competency-based training of the BSP or adequate collection, review and monitoring of data related to behaviors targeted for increase (e.g., functional equivalent replacement behaviors) or decrease.	Yes ☒ No ☐ Yes ☐ No ☒
#40	This individual was not included in the QSR study.	

ATTACHMENT 2
CHART B

Name	Compliance Question: *Are individuals' needs identified and met?*	Response
#1	This individual was not included in the QSR study.	
#2	QSR Auditor answered ISR Reviewer answered Issue identified, if ISR Reviewer answered No: The ISP states that this individual has on-going and significant behavioral and physical health needs, (e.g., pica, skin picking, dining protocols) and requires behavioral services. Clinician A is listed as the behaviorist in the ISP (3/1/2021 – 2/28/2022) documents. The individual's mother/guardian shared that Clinician A was the provider for only one week when the individual moved in with her current Sponsor Home provider over 5 years ago. Clinician A stopped working for the employer, and Clinician B replaced Clinician A in a timely manner. Clinician B, a BCBA, is listed as author of the BSP and author of training / observation documents. Clinician B ended his services early to mid-August 2021. A new behavior provider, Clinician C (credentials unknown) began, and had two visits in mid-August to take over from Clinician B. However, the agency that employs Clinician C has paused its community outreach and Clinician C's services. This individual's residential provider was informed in early September that behavioral services are paused until February 2022. Currently, (9/21/2021) there have been no behavioral providers in place since about mid-August 2021. This individual with significant behavioral needs will be without behavioral services for up to 7-months, while the residential providers attempt to run the BSP as best as they can without professional guidance and oversight. The BSP provided for review was determined to be inadequate given that it did not include minimal elements as prescribed by the Practice Guidelines. Within the BSP, it is of concern that	Yes ☒ No ☐ Yes ☐ No ☒

	there were no safety guidelines or crisis protocol procedures in place for occurrences of pica.	
#3	QSR Auditor answered ISR Reviewer answered Issue identified, if ISR Reviewer answered No: Almost every day, the individual exhibits serious behavior problems, such as aggression, threats, and property destruction. During the day of the ISR Reviewer interview, the individual had bitten a staff member and required physical restraint. There was no behavior plan in place. The provider had trouble finding a behavioral specialist. Coincidentally, one was identified at the time of completion of the ISR Review, but had not yet begun any services other than an initial review of documentation and current status.	Yes ☒ No ☐ Yes ☐ No ☒
#4	QSR Auditor answered ISR Reviewer answered Issue identified, if ISR Reviewer answered No: The provider's verbal reports indicate that individual has been discharged from behavioral services on or about early summer 2021, currently, there is no formal BSP in place, and no formal behavioral services by a BCBA or PBSF are occurring. Per documentation review, the individual received therapeutic consultation through Clinician A from August 2016 - May 2018, when Clinician A chose to end services. The BSP written by Clinician B is dated (initial plan) 2/7/19. This timing could indicate that he was without behavioral services from May 2018 through January 2019, up to 9 months. At the time of this review, behavioral services have already been cancelled by the behavioral provider, per verbal report of the residential provider. ISP (9/1/2021 – 8/31/2022) indicates that the group home will meet on a weekly basis to review and implement the behavior plan and provide needed interventions. Verbal reports by the provider indicate this is not happening, as behavioral services have not in been in place since spring/summer 2021. ISP (9/1/2021 – 8/31/2022) indicates services are occurring from behavioral therapist from [*provider name removed]*, however, there is an inconsistency in reporting/documentation, as verbal	Yes ☒ No ☐ Yes ☐ No ☒

	reports from residential provider indicate that the behavioral therapist from [*provider name removed*] had already discharged the individual prior to this ISP.	
#5	QSR Auditor answered ISR Reviewer answered Issue identified, if ISR Reviewer answered No: The behavior specialist (PBSF) provided some services (e.g., BSP development and remote staff training) more than one-year ago. She ended services about one-year ago because the individual was doing well. She made herself available if there should be a need. The individual's ISP (dated 11/1/20 – 10/31/21) stated that the individual needed behavioral services. The ISR Reviewer scored this question 'No' because the BSP did not meet the minimum elements required by the Practice Guidelines. The staff were no longer implementing the BSP as written and the individual continued to exhibit problem behaviors.	Yes ☒ No ☐ Yes ☐ No ☒
#6	QSR Auditor answered ISR Reviewer answered Issue identified, if ISR Reviewer answered No: This individual's ISP stated that behavioral services were needed. Although a BSP was in place, the BSP provided for review was determined to be inadequate given that it did not include minimal elements as prescribed by the Practice Guidelines. The BSP was not developed by a Licensed Behavior Analyst or Positive Behavior Support Facilitator. In addition, evidence of adequate ongoing data collection (including targets for increase and decrease) and review was not provided.	Yes ☒ No ☐ Yes ☐ No ☒
#7	QSR Auditor answered ISR Reviewer answered Issue identified, if ISR Reviewer answered No: This individual's ISP stated that behavioral services were needed. The BSP provided for review was determined to be	Yes ☒ No ☐ Yes ☐ No ☒

	inadequate given that it did not include minimal elements as prescribed within the Practice Guidelines. The behavior plan was lacking person centered information, numerous components of the FBA, methods of measurements for behaviors targeted for increase and decrease, and any data used for decision making. Additionally, the plan did not target inappropriate sexual behavior despite the ISP noting that the behavior was continuing to occur.	
#8	QSR Auditor answered ISR Reviewer answered Issue identified, if ISR Reviewer answered No: The Reviewer noted a lack of correspondence with the QSR Auditor regarding the status of the behavior support plan. That is, evidence indicated that the BSP (and included FBA) was outdated. The BSP provided for review was determined to be inadequate given that it did not include minimal elements as prescribed within the Practice Guidelines. In addition, the BSP did not formally address a life-threatening behavior (i.e., ingestion of inedible items) that necessitated previous emergency medical intervention. The author of the plan reported previous concerns regarding inadequate data collection and ineffective communication following incidents of significant unsafe behavior when the BSP was in effect. Evidence of adequate training of the BSP as well as ongoing data collection and review was not provided. In addition, current verbal reports by the provider indicated that the behavior support plan was no longer implemented even though the ISP (dated 9/1/20 – 8/31/21) indicated that therapeutic consultation behavior services were needed and that a formal behavior support plan was in place.	Yes ☒ No ☐ Yes ☐ No ☒
#9	QSR Auditor answered ISR Reviewer answered Issue identified, if ISR Reviewer answered No: Documentation reviewed showed no evidence of competency based BSP trainings. In addition, the BCBA notes that data collection and data observations are still an ongoing challenge. The BCBA believes that the residential provider is experiencing staffing and management changes, due to COVID-19; however, receiving behavioral data is inconsistent.	Yes ☒ No ☐ Yes ☐ No ☒

	Case management on-site visit tool (OSVT) notes for 3/18/21, 4/22/21, 5/21/21, 6/23/21: Each OSVT tool reviewed indicates "*YES*," for Q# 9: *Are behavioral services available and occurring as needed?* The OSVTs are found to be inaccurate, given that data collection has been troublesome for the BCBA (providers not sharing data, not taking data correctly, absence of some months of data), and the absence of approval for additional authorization hours per the BCBA's needs assessment and request that was made over 5-months ago at the time of this interview. Additional authorization was requested to support the individual in his new environment, help with his transition, and update programming to include his novel disruptive behavior in vehicles. The BSP provided for review was determined to be inadequate given that it did not include minimal elements as prescribed by the Practice Guidelines.	
#10	QSR Auditor answered ISR Reviewer answered Issue identified, if ISR Reviewer answered No: There is no BSP for this individual. A preliminary BSP was created almost a year ago, but never finalized. Staff have had to do their best without a BSP. The preliminary BSP was insufficient, that is, it did not meet state Practice Guidelines criteria for quality or completeness. The individual has 1:1 staffing and behavior problems that occur many times per month. Examples are emotional outbursts, self-injury, and assaults on others.	Yes ☒ No ☐ Yes ☐ No ☒
#11	QSR Auditor answered ISR Reviewer answered Issue identified, if ISR Reviewer answered No:	Yes ☒ No ☐ Yes ☒ No ☐
#12	This individual was not included in the QSR study.	
#13	QSR Auditor answered ISR Reviewer answered	Yes ☒ No ☐ Yes ☐ No ☒

	Issue identified, if ISR Reviewer answered No: Verbal reports from the residential provider indicate that it is very difficult to get behavioral services. It was shared with this reviewer that the Richmond agencies have a 30-miles radius and the town of Hopewell, VA is outside of this limit. Service availability has "gotten better" in last few months; however, over the years, this area of the state has been drastically underserved. PBSF is not presently providing behavioral services "now" at the time of this interview (9/27/21). She has been providing support as part of her schooling, which was part of her curriculum. She provided a "student" plan. Both the agency and PBSF have applied for authorization for behavioral services for the individual, and they are still waiting for authorization to be approved. The original application for authorization got lost or was not received. The PBSF had to re-start the process with authorization all over again. She shared with this reviewer that (as of 9/27/21), "authorization should be approved any day now." Verbal reports indicate that no formal behavioral services have been authorized, and that the PBSF is the first behavioral support provider for this individual at this residential provider. OSVTs (12/4/20), (3/10/21), & (6/11/21) all indicate "YES," that behavioral services are available and occurring as needed and as authorized. However, OSVT (12/4/20) notes: *Individual is in need of current behavioral supports due to instability with behavior looking to have a behavior specialist. (residential) Provider stated she may need a Behavior Specialist. Waiting on service authorization from [provider name removed].* OSVT (7/26/21) indicates "NO" that behavioral services are not available or occurring as needed and authorized, with a note: *Provider not seeing (her).* OSVT (7/26/21) indicates "YES" for Question 9a, that a behavior assessment <u>was</u> completed, but there are no other indications of checked or completed tasks in this 9a category. This reviewer was not provided with any behavioral assessment documentation. Verbal reports contradict the documentation in the case manager's OSVTs that indicates behavioral services were occurring. Verbal reports indicate that no formal behavioral services were authorized or occurring on or before the date of this interview on 9/27/2021. ISP (1/1/21 – 12/31/21) Health Information indicates "*no need for behavioral or mental health services,"* and indicates "*no identified behavioral health needs that require a referral to a behavior specialist.*"	

	RAT (1/1/21 – 12/31/21) indicates "*currently seeking behavior specialist with {provider name removed},*" and it is noted that this individual does not have a behavior plan in place to address any of the challenging behaviors mentioned in the SIS document dated 08/14/20	
#14	QSR Auditor answered ISR Reviewer answered Issue identified, if ISR Reviewer answered No: There was no behavior support plan in place and no immediate plans for there to be one. However, a BSP, involvement of a qualified and experienced behavior specialist, and ongoing staff training were very much needed. The individual's long history of assaultive and destructive behaviors requires a BSP. Staff were managing as best as they could, but behavior problems continued to occur. Documentation provided by the state would lead one to believe that the individual was doing well and did not need or want behavioral services. This was not the case and was misleading.	Yes ☒ No ☐ Yes ☐ No ☒
#15	QSR Auditor answered ISR Reviewer answered Issue identified, if ISR Reviewer answered No:	Yes ☒ No ☐ Yes ☒ No ☐
#16	QSR Auditor answered ISR Reviewer answered Issue identified, if ISR Reviewer answered No:	Yes ☒ No ☐ Yes ☒ No ☐
#17	This individual was not included in the QSR study.	
#18	QSR Auditor answered ISR Reviewer answered Issue identified, if ISR Reviewer answered No:	Yes ☒ No ☐ Yes ☐ No ☒

	The BSP provided for review was determined to be inadequate given that it did not include minimal elements as prescribed with the Practice Guidelines. The BSP was noted to be lacking in history and rationale, person centered information, components of the FBA, plan for training, signatures, and missing elements of the decision-making documentation.	
#19	This individual was not included in the QSR study.	
#20	QSR Auditor answered ISR Reviewer answered Issue identified, if ISR Reviewer answered No: There was a gap in services due to PBSF not being made aware of the individual's move, therefore services were not occurring for approximately 2-months from 7/9/2021 to September 1st 2021. No formal FBA or BSP completed. Behavioral services that she needs due to her numerous, frequent, and dangerous challenging behaviors were not occurring as needed. Within the OSVT documentation reviewed, tools completed on 4/21, 5/20, 7/21, and 8/21 respond to Q#9 "*Are behavioral services available and occurring as needed, and as authorized?*" as "Yes." Each OSVT is exactly the same, save one virtual visit on 4/21 where the Support Coordinator was unable to assess the environment due to a virtual visit. The Reviewer found no documentation or evidence that the requisite behavioral assessments or planning have occurred despite the individual's continuing challenging behaviors. The SIS dated 1/11/19 indicates that the BSP "went into effect," however, the Reviewer found no documentation of a formal BSP in place. The RAT for ISP dated 6/01/21 - 5/31/22 appears inconsistent in two specific sections. Section H Community Safety Risks Step 1 and Step 2 both indicate "No", she is not at risk, nor does she pose a risk. However, the next checkbox, Step 3, indicates "Yes" she does have a behavior plan or behavior guidelines related to these risks. For the Self-Harm, Elopement, Lack of Safety Awareness categories, all are checked off that they are "potential risk," however, no behavioral referrals have been made or indicated, all referral boxes on RAT are blank.	Yes ☒ No ☐ Yes ☐ No ☒

#21	This individual was not included in the QSR study.	
#22	QSR Auditor answered ISR Reviewer answered Issue identified, if ISR Reviewer answered No: The BSP provided for review was determined to be inadequate given that it did not include minimal elements as prescribed with the Practice Guidelines. The reviewed BSP was noted to be missing elements of the person-centered information, targeted behaviors for increase, plan for training, signatures, and the decision-making documentation. It should be noted however, that verbal reports indicated that the current behavioral services have led to significant reductions in many of the individual's challenging behavior. This was attributed to the training of staff and the flexibility and quality of the current behavior analyst.	Yes ☒ No ☐ Yes ☐ No ☒
#23	QSR Auditor answered ISR Reviewer answered Issue identified, if ISR Reviewer answered No: Although there was agreement between the Reviewer and the QSR Auditor regarding the identification of behaviors that could result in injury to self or others, there was a lack of agreement on the identification of other unsafe and disruptive behaviors in need of support. More specifically, reports evidenced behaviors that were disruptive to the environment, limited his ability to access a wide range of environments, and negatively impacted his quality of life and greater independence – these needs were not identified by the QSR auditor. The Reviewer noted that the exceptional behavioral needs identified within the SIS-A (dated 8/5/20) were not listed as identified needs in the ISP (dated 7/1/21 – 6/30/22). Case manager progress notes (dated 5/12/21, 6/3/21, 7/8/21, & 8/11/21) included descriptions of property destruction and inappropriate sexual behavior that was noted to be a continued challenge at home and at his day support. The ISP (dated 7/1/21 – 6/30/22) highlighted his inappropriate sexual	Yes ☒ No ☐ Yes ☐ No ☒

	behavior (e.g., excessive masturbation, masturbation in public areas, attempting to touch others) that required supervision at home, the day program, and in the community. In addition, descriptions suggested that he may become 'stubborn' at times that may lead to physical aggression. Descriptions indicated that he would have to be continuously monitored due to his inappropriate sexual behaviors and stealing at home and in the community. The Reviewer was concerned that the ISP did not recommend therapeutic consultation behavior supports or a formal behavior support plan.	
#24	QSR Auditor answered ISR Reviewer answered Issue identified, if ISR Reviewer answered No: The individual is engaging in some severe, potentially life-threatening behavior. During the first month she lived with FLS, she would have SIB / Attempted Suicide weekly, currently, it is about 1x/month. The PBSF who wrote the 2019 FBA/BSP (dated 5/14/2019 – her discharge on 7/31/2019), for [Provider Name removed] then she was discharged in 7/19 after approximately 2 months of behavior plan implementation. The PBSF was told that the "plan wasn't working" and the challenging behaviors were too problematic for this residence. The individual was discharged to [*provider name removed*] on 7/9/19. The Mental Health Therapist / Owner at [*provider name removed*] is running her own supportive plan for coping strategies and strategies for staff. She reported that the BSP from 2019 is no longer in place. The BSP provided for review (2019) was determined to be inadequate given that it did not include minimal elements as prescribed by the Practice Guidelines. There are no formal behavioral services in place. There is no BCBA or PBSF in place, no formal BSP in place.	Yes ☒ No ☐ Yes ☐ No ☒

	In this reviewer's estimation, the severity, frequency, and potential for harm of the challenging behaviors requires the attention of a licensed BCBA.	
#25	QSR Auditor answered ISR Reviewer answered Issue identified, if ISR Reviewer answered No: The BSP was more than one and a half years old and had been discontinued by the provider and parent/guardian. The BSP did not meet minimum state criteria for content and quality. No data were being collected. Even so, the individual's status was described, during interview, as being stable and that the individual was overall doing well. However, given the individual's history of challenging behavior, some behavioral services were warranted, even if it is as a type of consultant to the support team to provide input from a behavioral services/behavior analytic perspective.	Yes ☒ No ☐ Yes ☐ No ☒
#26	QSR Auditor answered ISR Reviewer answered Issue identified, if ISR Reviewer answered No: The BSP provided for review was determined to be inadequate given that it did not include minimal elements as prescribed with the Practice Guidelines. The reviewed BSP was noted to be missing elements of demographics, history and rationale, person centered information, FBA, targeted behaviors for decrease, plan for training, signatures, and decision-making documentation.	Yes ☒ No ☐ Yes ☐ No ☒
#27	QSR Auditor answered ISR Reviewer answered Issue identified, if ISR Reviewer answered No: There was a BSP, but it was more than one year old and there has been no involvement of a behavior specialist since then.	Yes ☒ No ☐ Yes ☐ No ☒

	The behavior plan is not being followed and data are not collected. The BSP did not meet the State's minimum criteria for content and quality. The provider reported that the individual was doing well and that a behavior specialist and BSP were not needed. However, there are reasons why behavior supports should be accessed and why the individual's needs are not being met without this involvement. First, the individual has a long history of challenging behavioral issues and some input from a behavior specialist can help inform the provider and team, such as by considering variables in behavior occurrence from a behavior analytic perspective. Second, the individual was being treated with psychotropic medications that had side effects. These were affecting the individual's ability to engage in conversation, mobility, and fine motor skills, such as dressing and participating in general home activities (e.g., cooking, laundry).	
#28	This individual was not included in the QSR study.	
#29	QSR Auditor answered ISR Reviewer answered Issue identified, if ISR Reviewer answered No: The BSP provided for review was determined to be inadequate given that it did not include minimal elements as prescribed with the Practice Guidelines. The reviewed BSP was noted to be missing elements of the demographics, history and rationale, person centered information, the FBA, plan for training, signatures, and the decision-making documentation.	Yes ☒ No ☐ Yes ☐ No ☒
#30	QSR Auditor answered ISR Reviewer answered Issue identified, if ISR Reviewer answered No: The ISR Reviewer answered this No because the BSP did not meet the State's minimum requirements for content and quality. The requirements that did not meet criteria were regarding	Yes ☒ No ☐ Yes ☐ No ☒

	targeted behaviors for increase (e.g., definition, examples, measurement),	
#31	This individual was not included in the QSR study.	
#32	QSR Auditor answered ISR Reviewer answered Issue identified, if ISR Reviewer answered No: Per the current ISP (dated 7/1/21 – 6/30/21), identified needs included the prevention of property destruction, self-injury, wandering and pica. Provided data on pica, physical aggression, self-injurious behavior (SIB) and disruptive behavior – collected at the residence between July 2020 and June 2021 – revealed that pica occurred several times per week, physical aggression occurred at least once (or more) per month in 8 of 12 months, SIB occurred at least once (or more) per month in 9 of 12 months, and disruptive behavior occurred at least once (or more) per month in 11 of 12 months. Data from the day program also indicated that aggression, SIB, and disruptive behavior also occurred frequently most months between March 2021 and June 2021. It was noted within the ISP (dated 7/1/21 – 6/30/21) that therapeutic consultation behavioral services were required and that a formal behavior support plan was in place. Indeed, a behavior support plan targeting identified needs was reportedly implemented and provided for review. However, the BSP was inadequate as it did not include minimal elements as prescribed by the Practice Guidelines. The reviewed BSP was noted to be missing elements of the demographics, person centered information, behaviors targeted for increase, plan for training, appropriate signatures, and decision-making documentation.	Yes ☒ No ☐ Yes ☐ No ☒
#33	QSR Auditor answered ISR Reviewer answered Issue identified, if ISR Reviewer answered No: Residential provider indicated that they had insufficient support from REACH. The individual would repeat *"I am asking for help, I am going through a psychiatric episode right now, why won't they help*	Yes ☒ No ☐ Yes ☐ No ☒

	me?" Residential provider reached out several times to request more supports and was denied access to inpatient care. Since data collection started in November 2019, the last two months recorded, July & August 2021, evidence higher frequency of challenging behaviors; visual analysis would suggest that his target behaviors for decrease are "getting worse". The BSP provided for review was determined to be inadequate given that it did not include minimal elements as prescribed by the Practice Guidelines. In addition, evidence of adequate ongoing data collection (including targets for increase and decrease) and review was insufficient and incomplete, possibly inaccurate, for the exhibited challenging behaviors.	
#34	QSR Auditor answered ISR Reviewer answered Issue identified, if ISR Reviewer answered No: The ISP (dated 10/1/20-9/30/21) indicates that this individual requires routines and a structured environment to prevent emotional outbursts, property destruction, assaults, and self-injury. The ISP also identified behavioral strategies that can be used to prevent challenging behavior (pre-teaching and providing reinforcement), the use of environmental modifications (avoiding certain clothes to prevent nonaggressive but inappropriate sexual behavior), and staff responses to challenging behavior. The ISP also notes that this individual was supported with a behavior plan at his residential school and that the proactive and reactive strategies from that behavior plan were copied and pasted into the Part V: Sponsored Residential (dated 10/1/20-9/30/21). Verbal reports indicated that staff are trained by having them review this document. Verbal reports and the ISP also indicated that this is sufficient for training staff and managing challenging behavior. However, with no formal behavior plan there is no clinical oversight of the interventions, no behavior tracking, and no formal means of identifying whether there is a need for change in intervention over time.	Yes ☒ No ☐ Yes ☐ No ☒
#35	QSR Auditor answered	Yes ☐ No ☒

	ISR Reviewer answered Issue identified, if ISR Reviewer answered No: The Reviewer noted that the exceptional behavioral needs identified within the SIS-A (dated 7/5/19) were not listed as identified needs in the ISP (dated 10/1/21 – 9/30/21). More specifically, the SIS-A indicated that she required extensive support for the prevention of emotional outbursts, assaults or injurious to others, stealing, self-injury, pica, inappropriate social behavior, and wandering. The ISP only included descriptions of her self-injury. Verbal report estimated that her SIB was likely to occur almost daily. In addition, verbal reports estimated that aggression and fecal smearing occurred several times per week. The ISP also indicated that she required a referral for therapeutic consultation behavioral services and that a formal BSP was needed. However, current verbal reports indicated that no behavioral consultation services had been obtained and that no formal BSP was in place. Verbal report indicated that the demand for behavioral services was greater than the current supply in their community and that the current wait time (estimated to be 6 months to 1 year) was typical due to the insufficient availability of behavior services.	Yes ☐ No ☒
#36	QSR Auditor answered ISR Reviewer answered Issue identified, if ISR Reviewer answered No: The SIS-A (dated 7/14/20) indicated that he required extensive support for the prevention of emotional outbursts, assaults or injurious to others, property destruction, self-injury, inappropriate social (sexual) behavior, and elopement as well as some support for the prevention of stealing, sexual aggression, and maintaining mental health treatments (i.e., compliance with his medication compliance). At the time the ISP (dated 5/1/21 – 4/30/22) was written, it indicated that he was awaiting discharge from Western State Hospital. Descriptions noted that he was previously hospitalized at Western State Hospital from 12/6/19 – 5/15/20 and had been re-admitted on 6/11/20 and was waiting discharge (planned for end of April 2021) to a	Yes ☒ No ☐ Yes ☐ No ☒

	community-based group home. Verbal report indicated that these hospitalizations were due to his aggressive behavior. More recent therapeutic consultation services team meeting notes (dated 7/21/21, 7/29/21 & 8/3/21) described incidents of physical aggression, SIB, and inappropriate social behavior (masturbating in a public area of the home). It was noted within the ISP (dated 5/1/21 – 4/30/22) that he had a formal BSP. However, a formal BSP was not provided for review and verbal reports indicated that, although they were in progress, an FBA and BSP had not yet been completed.	
#37	This individual was not included in the QSR study.	
#38	QSR Auditor answered ISR Reviewer answered Issue identified, if ISR Reviewer answered No: Although there was agreement between the Reviewer and the QSR Auditor regarding the identification of behaviors that could result in injury to self or others, there was a lack of agreement on other behaviors that needed support. More specifically, reports evidenced behaviors that were disruptive to the environment, that impeded his ability to access a wide range of environments, that impeded his ability to learn new skills, and that negatively impacted his quality of life and greater independence. In addition, the Reviewer, unlike the QSR Auditor, noted that both physical and chemical restraints were utilized. Residential quarterly reports (dated 12/1/20 – 2/28/21) evidenced incidents of self-injurious behavior (requiring first aid), property destruction (e.g., tampering with electrical cords, loosening water supply hoses in the bathroom), and multiple episodes of urinary and fecal incontinence that was reportedly done on purpose. Descriptions also revealed the frequent use of PRN medication (Clonazepam). Residential quarterly report (dated 3/1/21 – 5/31/21) evidenced incidents of emotional outbursts, self-injurious behavior (e.g., removed his fingernail) that required staff intervention (including first aid), physical aggression (toward a peer and staff) and property destruction (including taking apart	Yes ☒ No ☐ Yes ☐ No ☒

	his alarm clock and attempting to break the pantry door). In addition, he had multiple episodes of urinary and fecal incontinence that was reportedly very disruptive and done on purpose. Further notation revealed that he was physically restrained during an aggressive incident (on 5/15/21) as well as received his PRN medication (Clonazepam) on multiple occasions. Overall, although verbal reports indicated that his behavior had significantly improved since his admission, he continued to display behavior that placed him and others at risk of injury and that led to injury requiring first aid, the use of PRN medication, and physical restraint. There is no formal behavior support plan currently in place. The ISP (dated 3/1/21 – 2/28/22) indicated that referral for therapeutic behavior consultation as well as a formal BSP was not needed. The Reviewer determined, however, that formal behavioral assessment and intervention was necessary given the nature of the unsafe and disruptive behavior and related outcomes. When questioned about the availability of behavioral services in their area, verbal reports indicated that care providers had great difficulty in the past when trying to access available behavioral service providers. When questioned about current availability, verbal reports indicated that they would likely have great difficulty in accessing behavioral consultation given the absence of appropriate providers.	
#39	QSR Auditor answered ISR Reviewer answered Issue identified, if ISR Reviewer answered No: The individual's BSP was more than one year old, did not meet the State's minimum requirements for content and quality, and there was little evidence of staff training. The individual continued to exhibit problem behaviors, including aggression (sometimes to a police officer) and running away from the group home (sometimes for days at a time).	Yes ☒ No ☐ Yes ☐ No ☒
#40	This individual was not included in the QSR study.	

Attachment 3

MONITORING QUESTIONNAIRE

UNITED STATES v. VIRGINIA

SECTION 1: Demographics

1. **Individual's Name**:

2. **Age Range**:

   ☐ under 21 ☐ 21-30 ☐ 31-40 ☐ 41-50 ☐ 51-60 ☐ 61-70 ☐ 71-80 ☐ 81-90

3. **Gender**: ☐ Male ☐ Female

4. **Residential Provider**:

5. **Address**:

6. **Telephone Number**:

7. **Type of Residence**:

   ☐ Family/Own Home
   ☐ Sponsor Home
   ☐ Supported Apartment
   ☐ Group Home
   ☐ ICF
   ☐ Other (please specify):

8. **Documents Reviewed**:

9. **Interviews Conducted**:

SECTION 2: Need for Behavioral Support

1.	Does the individual engage in any behaviors (e.g., self-injury, aggression, property destruction, pica, elopement, etc.) that could result in injury to self or others? If Yes, describe the behavior and how often it occurs:	☐Yes ☐No
2.	Does the individual engage in behaviors (e.g., screaming, tantrums, etc.) that disrupt the environment? If Yes, describe the behavior and how often it occurs:	☐Yes ☐No
3.	Does the individual engage in behaviors that impede his/her ability to access a wide range of environments (e.g., public markets, restaurants, libraries, etc.)? If Yes, describe the behavior and how often it occurs:	☐Yes ☐No
4.	Does the individual engage in behaviors that impede his/her ability to learn new skills or generalize already learned skills? If Yes, describe the behavior and how often it occurs:	☐Yes ☐No
5.	Does the individual engage in behaviors that negatively impact his/her quality of life and greater independence? If Yes, describe the behavior and how often it occurs:	☐Yes ☐No

SECTION 3: Supplemental Questions

6.	Has there been a psychiatric hospitalization? If yes, list the date he/she was hospitalized and the length of stay:	☐Yes ☐No
7.	Has there been an emergency room visit or unexpected medical hospitalization? If yes, list the date(s) and the reason(s):	☐Yes ☐No
8.	Has there been use of physical, chemical, or mechanical restraint? If yes, list the date and reason:	☐Yes ☐No
9.	Have any rights been restricted (e.g., locked food, restricted access to clothing or other items, etc.)? If yes, describe the reason and the actions planned to regain rights and/or minimize the impact:	☐Yes ☐No

SECTION 4: Nature of Behavioral Support

10.	Was there evidence that an FBA was completed? If yes: a. Was the FBA developed or updated within the last 12 months? b. Was the FBA completed by a Licensed Behavior Analyst or a Positive Behavior Support Facilitator?	☐Yes ☐No ☐Yes ☐No ☐Yes ☐No

11.	Was there evidence that a BSP was completed and implemented? If yes: a. Was the BSP developed (or updated) within the last 12 months? b. Was the BSP developed for the current setting? c. Was the BSP developed by a Licensed Behavior Analyst or a Positive Behavior Support Facilitator? d. Is the BSP currently overseen by the author or similarly trained clinician?	☐Yes ☐No ☐Yes ☐No ☐Yes ☐No ☐Yes ☐No ☐Yes ☐No

SECTION 5: BSPARI Summary

If "Yes" on Item #11, then score Items #12-24; If 'No", skip items #12-24.

12.	Demographics: Was there evidence that all minimum elements were present?	Points ___ ☐Yes ☐No
13.	History & Rationale: Was there evidence that all minimum elements were present?	Points ___ ☐Yes ☐No
14.	Person Centered Information: Was there evidence that all minimum elements were present?	Points ___ ☐Yes ☐No
15.	FBA: Was there evidence that all minimum elements were present?	Points ___ ☐Yes ☐No
16.	Hypothesized Functions: Was there evidence that all minimum elements were present?	Points ___ ☐Yes ☐No

17.	Behaviors Targeted for Decrease: Was there evidence that all minimum elements were present?	Points ___ ☐Yes ☐No
18.	Behaviors Target for Increase: Was there evidence that all minimum elements were present?	Points ___ ☐Yes ☐No
19.	Antecedent Interventions: Was there evidence that all minimum elements were present?	Points ___ ☐Yes ☐No
20.	Consequential Interventions: Was there evidence that all minimum elements were present?	Points ___ ☐Yes ☐No
21.	Safety and Crisis Guidelines: Was there evidence that all minimum elements were present?	Points ___ ☐Yes ☐No ☐NA
22.	Plan for Training: Was there evidence that all minimum elements were present?	Points ___ ☐Yes ☐No
23.	Appropriate Signatures: Was there evidence that all minimum elements were present?	Points ___ ☐Yes ☐No
24.	Decision Making Documentation: Was there evidence that all minimum elements were present?	Points ___ ☐Yes ☐No

SECTION 6: Training, Monitoring, & Service Implementation

If "Yes" on Item #11, then score Items #25-27; If "No" score items #25-27 "NA"

25.	Was there evidence (documentation) that care providers who support the individual successfully completed competency-based training on the current BSP within the last year?	☐Yes ☐No ☐NA
26.	Did verbal reports from care provider(s) indicate that the Behavior Support Plan was implemented with a high degree of fidelity?	☐Yes ☐No ☐NA
27.	Were changes made to the BSP, as appropriate?	☐Yes ☐No ☐NA
28.	Are behavioral services available and occurring as needed, and as authorized?	☐Yes ☐No ☐NA

REVIEWER'S NOTES

ISSUES

Reviewer's Name / Title:

Date(s) of Review:

Attachment 4

Document Request

The following documents will be obtained, organized and made electronically accessible to the current study's author and other reviewer(s):

- Practice Guidelines developed by the Commonwealth (on the minimum elements that constitute an adequately designed behavioral program and use of positive behavior support practices)
- Evidence that the Practice Guidelines were provided to behavior consultants by the Commonwealth
- Permanent DD waiver regulations, including expectations for behavioral programming and the structure of behavioral support plans, and evidence (including date) that they were approved
- Summarized results and findings for the selected individual and documentation related to the QSR study DBHDS's 2021 QSR study DBHDS's 2021 QSR study

For each selected individual:

- The Service Eligibility Assessment (e.g., SIS) which placed the individual in level 7 for the QSRs.
- Current Individual Support Plan (ISP) (including Section V for any care provider involved with participating in the delivery of behavioral supports)
- Current Functional Behavior Assessment (FBA)
- Current Plan for Supports (aka Behavior Support Plan, Behavior Intervention Plan, Positive Behavior Support Plan, or similar)
- Behavior related training documentation relative to the current plan for supports (i.e., to evidence training provided to family members or providers, and their supervisors who are providing behavior programming)
- Copy of a current blank data sheet (i.e., used to track behaviors targeted in the plan for supports)
- Data for target behavior (behavior to decrease) and replacement behavior (behavior to increase) for the last three months
- Data summaries (e.g., monthly) and/or graphed data and analysis (from the last three months) reflective of ongoing data review
- Any documentation of the case managers' assessments of the appropriate implementation of behavioral supports and any related changes of status, as applicable.
- Any documentation reflective of revisions or amendments to the Plan for Supports (or the need thereof)
- Other documentation and/or notes reviewed and/or completed by the 2021 QSR study reviewers during the period of the review

APPENDIX B

By

Kathryn du Pree, MPS

And

Joseph Marafito, MS

2021 REVIEW OF THE INTEGRATED DAY AND EMPLOYMENT SERVICES REQUIREMENTS OF THE US v COMMONWEALTH OF VIRGINIA'S SETTLEMENT AGREEEMENT

REVIEW PERIOD: OCTOBER 1, 2020– SEPTEMBER 30, 2021

SUBMITTED TO DONALD FLETCHER

INDEPENDENT REVIEWER

BY: KATHRYN DU PREE, MPS

EXPERT REVIEWER

November 1, 2021

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Overview of Requirements

Donald Fletcher, the Independent Reviewer, has contracted with Kathryn du Pree as the Expert Reviewer to perform the review of the integrated day activities and employment services requirements of the Settlement Agreement for the time period 10/01/20–9/30/21. The purpose of the review is to determine the extent of the Commonwealth's progress implementing plans to achieve the requirements of the Settlement Agreement focused on employment and integrated day activities (III.C.7.a.-b.) This report of integrated day services will review evidence that the Commonwealth has completed the required determination process and has verified the accuracy and completeness of the Commonwealth's data and documentation of its efforts to achieve the requirements of the applicable compliance indicators.

Virginia has been implementing progressive changes to its employment service array for individuals with intellectual and developmental disabilities (I/DD) since 2012. This is the third consecutive review that covers a twelve-month period. The Independent Reviewer determined it is more useful to review the relevant data over a twelve-month, rather than a six-month, period to provide a greater understanding of the advances that are being made and to provide a longitudinal view of the Commonwealth's efforts to address challenges and implement policy and funding changes.

Facts were gathered regarding the Commonwealth's progress related to the provisions of the Settlement Agreement in Sections III.C.7.a. and b. The focus for the provisions studied will be to review the Commonwealth's progress toward achieving the indicators including the progress of its CSBs to address employment and community engagement in the individual planning process discussing and developing employment and community integration goals for individuals at least annually and including these related goals in the ISP.

Settlement Agreement Provisions

The provision of III.C.7.a is: 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.

The report from this period will include data and findings of the Commonwealth of Virginia's progress toward achieving the following requirements:

The review will determine the Commonwealth of Virginia's compliance with the following requirements:

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

7.b. The Commonwealth shall maintain its membership in the State Employment Leadership Network (SELN) established by NASDDDS; establish state policy on Employment First for the target population and include a term in the CSB Performance Contract requiring application of this policy; [use] the principles of employment first include offering employment as the first and priority service option; providing integrated work settings that pay individuals minimum wage; discussing and developing employment options with individuals through the person-centered planning process at least annually; and employ at least one employment services coordinator to monitor the implementation of employment first practices.

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

- *A. Provide regional training on the Employment First policy and strategies throughout the Commonwealth; and*
- *B. Establish, for individuals receiving services through the HCBS waivers:*
  - *1. Annual baseline information regarding:*
    - *a. The number of individuals receiving supported employment;*
    - *b. The length of time people maintain employment in integrated work settings;*
    - *c. The amount of earnings 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 lengths of time individuals remain in pre-vocational services*
  - *2. Targets to meaningfully increase:*
    - *a. The number of individuals who enroll in supported employment in each year; and*
    - *b. The number of individuals who remain employed in integrated work settings at least 12 months after the start of supported employment*

III.C.7.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.

III.C.7.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.

Compliance Indicators

The Parties have jointly agreed to several compliance indicators (CI) for provisions of the Settlement Agreement (SA) for which the Commonwealth has not met or sustained compliance. The CIs that are relevant for the employment provisions of the SA are detailed below. This review focuses on determining if the Commonwealth has reliable data to demonstrate compliance and if the expected levels of compliance have been achieved.

III.C.7.a. and b: The requirements of these sections of the SA are now numbered as CIs as follows:

CI 14.01 All case managers are required to take online case management training modules and review the case management manual. Information contained includes:

a. The Employment First Policy with an emphasis on the long-term benefits of employment to people and their families and practical knowledge about the relationship of employment to continued Medicaid benefits.
b. Skills to work with individuals and families to build their interest and confidence in employment.
c. The importance of discussing employment with all individuals, including those with intense medical and behavioral support needs and their families.
d. The importance of starting the discussion about employment with individuals and families as early as the age of 14 with goals that lead to employment (e.g., experiences in the community, making purchases, doing chores, volunteering).
e. The value of attending a student's IEP meeting starting at age 14 to encourage a path to employment during school years and to explore how DD services can support the effort.
f. Developing goals for individuals utilizing Community Engagement Services that can lead to employment (e.g., volunteer experiences, adult learning).
g. Making a determination during their monitoring activities as to whether the person is receiving support as described in the person's plan and that the experience is consistent with the standards of the service.

The Commonwealth will achieve compliance with this provision of the Settlement Agreement as indicated by the following CIs:

CI 14.02 At least 86% of individuals (age 18-64) who are receiving waiver services will have a discussion regarding employment as part of the ISP planning process.

CI 14.03 At least 50% of ISPs of individuals (age 18-64) who are receiving waiver services include goals related to employment.

CI 14.04 At least 86% of individuals who are receiving waiver services and have employment services authorized in their ISPs will have a provider and begin services within 60 days.

CI 14.05 At least 86% of individuals who are receiving waiver services will have a discussion regarding the opportunity to be involved in their community through community engagement services provided in integrated settings as part of their ISP process.

CI 14.06 At least 86% of individuals who are receiving waiver services will have goals for involvement in their community developed in their annual ISP.

CI 14.07 At least 86% of individuals aged 14-17 who are receiving waiver services will have a discussion about their interest in employment and what they are working on while at home and in school toward obtaining employment upon graduation, and how the waiver services can support their readiness for work, included in their ISP.

CI 14.08 New Waiver Targets established by the Employment First Advisory Group. The data target for FY20 is 936 individuals in ISE and 550 individuals in GSE for a total of 1486 in supported employment. Compliance with the Settlement Agreement is attained when the Commonwealth is within 10% of the targets.

CI 14.09 The Commonwealth has established an overall target of employment of 25% of the combined total of adults ages 18-64 on the DD waivers and waitlist.

CI 14.10 DBHDS service authorization data continues to demonstrate an increase of 3.5% annually of the DD Waiver population being served in the most integrated settings as defined in the Integrated Employment and Day Services Report (an increase of about 500 individuals each year as counted by unduplicated number recipients).

II. Sixteenth and Seventeenth Review Findings

The Provisions of the Settlement Agreement and the CIs that the Parties agreed to were reviewed during the 16th and 17th review periods. At that time DBHDS had sustained its previous achievement of meeting the requirements of the following Provisions: *7.b.iB.1. a.-e; III.C.7.b; III.C.7.d. DBHDS had also met the requirements of III.C.7.c., with the exception of the Regional Quality Councils consulting with providers regarding the need to take additional measures to further enhance these services. The RQCs did consult with the SELN (Employment First Advisory Group (E1AG), regarding the need to take additional measures which is also a component of this Provision. The Commonwealth did not meet the requirements of any of the ten* ***CIs (14.01-14.10)*** *agreed to by the Parties related to employment or community engagement during the 16th/17th reporting period.*

III. Executive Summary of Eighteenth and Nineteenth Review

The Commonwealth has struggled to further its achievement of the requirements of the SA that relate to employment and community engagement. Both DBHDS and DARS remain committed to the Commonwealth's Employment First Initiative. This is evidenced by the interagency collaboration on many related projects; the commitment of state and waiver funding to support ISE and GSE services; the continuation of the E1AG; the expansion of the E1AG to include members who represent both mental health and substance abuse; the new initiatives to assist individuals with these conditions to be employed; and the implementation of Customized Employment for individuals with I/DD or mental health concerns. However, the Commonwealth has achieved less this year than in past years and there has been a decline in meeting the targets.

The Commonwealth's achievement of requirements related to Community Engagement (CE) has declined. While DBHDS continues to have a strong commitment to CE, its ability to implement necessary activities to promote CE was weaker during the pandemic as resources and planning needed to be devoted to mitigating the impact of COVID on individuals, families and providers. Fewer individuals are authorized for this service and there is a lack of understanding by Case Managers (CMs) as to its importance as a service and its potential to help individuals with I/DD develop employment and related social skills. Much of this regression in both employment and CE can be attributed to the COVID 19 pandemic. For much of the review period individuals were unable to go to their jobs and there were fewer opportunities to engage safely in community activities.

The Commonwealth was able to sustain it achievements of the Provisions listed in Section II.

The CIs relevant to the employment and community engagement requirements of the SA are listed in Section I. These relate to case management training of the Commonwealth's expectations for these services; discussion and goal setting for employment and CE; discussion of the importance of work starting at age 14; timely implementation of employment service authorizations; and targets for employment for individuals with I/DD.

The Commonwealth fully met the requirements of ***CI 14.01 a.-g.*** During this reporting period the Commonwealth failed to meet any of these ***CIs: 14.02-14.10.*** DBHDS did not verify its data sources or the validity of its methodologies for ***CI's 14.02-14.07.*** Neither did the Commonwealth meet the actual requirements of any of these CIs. It was unable to provide any data for ***CI 14.04.*** As a result, the Commonwealth does not meet the requirements for ***CI 37.07.***

DBHDS had already provided the monitoring information to determine the validity of the data used for ***CI's 14.08, 14.09 and 14.10*** in the 16th/17th review period. However, the Commonwealth did not meet these employment targets in this current review period.

IV. Purpose of the Eighteenth and Nineteenth Review

This review will build upon the review completed last fall by the Expert Reviewer for the review period 10/01/19 through 9/30/20 and the related recommendations the Independent Reviewer made in his last Report to the Court. The focus of this review is to determine Virginia's progress toward achieving compliance with the indicators noted above where compliance has not been previously achieved but will also briefly address all areas of compliance related to employment services to make sure that the Commonwealth has sustained compliance in areas achieved during the previous reporting period. The focus of this review will be on:

- The expectation that individuals in the target population are offered employment as the first option by Case Managers and their teams during the individual planning process in which they discuss and develop employment goals.
- The Commonwealth's success meeting the FY 2021 targets it set for the number of people, members of the target population, who are in supported employment.
- The Commonwealth's progress to offer community engagement and community coaching to individuals who do not work or as a supplement to employment.
- The training CMs have received regarding employment options for individuals with I/DD and facilitating discussions and setting goals regarding employment with these individuals.

This report includes data and analysis of both the aspects of the IDA requirements of the SA where compliance has been previously achieved to determine if compliance has been sustained, and of DBHDS' efforts to meet the expectations of the agreed upon ***CIs 14.01-14.10.*** The reports that DBHDS provides contain data that is relevant to the CIs along with other requirements of the SA. Determinations of some of the CIs are included in the narrative as data is analyzed by topic area of this report. Compliance for all of the agreed upon CIs is summarized in Section IX.

V. Methodology and Review Process

To complete this review and determine compliance with the requirements of the Settlement Agreement, I reviewed relevant documents and interviewed key administrative and quality improvement staff of DBHDS, and members of the Employment First Advisory Group (E1AG), previously known as the SELN-Virginia. In July 2021, prior to initiating this review, a kickoff meeting was held with the Independent Reviewer, the Expert Reviewer, Heather Norton, Stephanie Subedi, Employment Specialist, and Jenni Schodt to review the process and to clarify any components of the review and the qualitative study. The Commonwealth was also asked to provide any additional documents that it maintains to demonstrate that it is properly implementing the Settlement Agreement's provisions related to integrated day and employment services.

I engaged in the following activities to review and analyze the DBHDS' progress to meet the Compliance Indicators for integrated day activities to increase the number of individuals who are engaged in supported employment or who are competitively employed, and those who are receiving Community Engagement. I reviewed the methodology that DBHDS is using to verify that its documents and reports include reliable; that the data align fully with all CIs for integrated day activities and supported employment; and that the specific steps that it used to make its calculations and determinations of compliance are valid and statistically significant. I also reviewed whether the Commonwealth fulfilled the requirements of compliance indicator 37.07 to determine that its data is reliable and valid and available for compliance reporting. However, DBHDS was only able to share the methodology it used to produce and verify data related to ***CIs 14.08 and 14.09.*** This study's methodology included a review of documents that are listed below and interviews with DBHDS staff and community stakeholders. These documents and interviews provide data regarding the Commonwealth's progress achieving the CIs, but it is not possible to confirm in this reporting period that the data is valid and statistically significant. DBHDS did not provide its determinations that the data reported related to Integrated Day Activities and Supported Employment were reliable and valid and available for compliance reporting. This will be discussed in greater detail on the body of this report.

The documents include the summary of the retrospective review completed by the Office of Community Quality Management (CQM) staff. In addition, I reviewed the same 100 ISPs that were reviewed in the Service Coordinator Quality Retrospective (SCQR) review for FY21 to validate whether the information in each ISP documents the team discussions regarding employment and community engagement and goal setting for both service types as a check on the DBHDS review process. The compliance indicators require that these conversations occur. The Commonwealth has set the targets for both a discussion about employment and setting employment goals. Case Managers (CMs) are expected to have discussions with 86% of the adults who have an Individual Service Plan (ISP), and to set employment goals for 50% of the adults. CMs are also expected to have discussions with 86% of the individuals they support to explore involvement in the community through the use of Community Engagement (CE) and Community Coaching (CC) services and set a goal in the area of community engagement for 86% of the individuals. This study is further detailed, and the findings are presented in a separate report titled: Integrated Day Activities Qualitative Study for the 19th Review Period, which was submitted to the Independent Reviewer. It is included as an Attachment to this report.

Document Review: Documents reviewed include:

1. VA DBHDS Employment First Project Plan: FY2020-2023 Update
2. DBHDS Semiannual report on Employment (through 12/31/20)
3. DBHDS Semiannual report on Employment (draft through 06/30/21)
4. Regional Quality Council (RQC) meeting minutes and recommendations for implementing Employment First
5. Employment First Advisory Group (E1AG) meeting minutes
6. Case Management Training Module 11: Employment -revisions to address CI requirements and related training materials

7. Support Coordinator Quality Reviews Methodology and Supporting Processes and Draft Reports for FY21
8. Employment Discussions ages 14-17
9. Table 1- Number of Recipients of Integrated Employment and Day Services by Procedure Code through 3/31/21
10. Monitoring Questionnaire for Data Verification for ***CIs 14.08 and CI 14.09***
11. Monitoring Questionnaire for Data Verification for ***CIs 14.02,14.03, 14.05,14.06,14.07 and 14.08*** developed for FY22 Data

Interviews: The Expert Reviewer interviewed members of the E1AG; Heather Norton, Assistant Commissioner, Developmental Services, DBHDS; Stephanie Subedi, DBHDS Employment Specialist; Christi Lambert, Team Lead, Office of Community Quality Improvement, DBHDS; and Britton Welch, Director of the Office of Community Quality Management DBHDS.

I appreciate everyone's willingness to participate in interviews and for the work of DBHDS staff to share numerous individual plans and reports. All of the interviews provide information that contribute to a more robust report. The graphs in this report are taken from DBHDS' Semiannual Employment Report through June 2021.

VI. The Employment Implementation Plan

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

Review of the Division of Developmental Services: Employment First Project Plan-FY 2021-2023

DBHDS shared its updated project plan for its Employment First outcomes and strategies. The plan includes the intended outcomes and benchmarks for FY21- FY23. It then lists the action steps it plans to engage in to achieve the desired outcomes. DBHDS did not provide a status report of its completion of products or timelines towards implementing the activities or meeting the benchmarks. Below is a summary of the Project Plan's outcomes, benchmarks and activities provided by DBHDS.

Desired Outcomes, Benchmarks and Activities for the Employment First Project

Outcome 1: Maintain collaboration between state agencies that facilitate employment for individuals with intellectual and developmental disabilities (ID/DD), Serious Mental Illness (SMI), & Substance Use Disorder (SUD).

Benchmarks for Success: Individual Agency policy difference do not impede provision of services to individuals; Memorandums of Understanding that include commitment to efforts to

collaborate and resolve differences and inconsistencies; Alignment of state regulation and administrative policy with Employment First policies and values.

Activities: DBHDS collaborates with the other relevant state agencies including DARS, DMAS, DOE and Workforce for technical assistance; collaborates with DMAS and DARS for High Needs Support (HNS) for supported employment; collaborates with DMAS on the HCBS project; collaborates with DOE and VCU on employment pathways for transitioning youth; establishes MOUs; and identifies common language used by involved state agencies to create a cross reference.

Outcome 2: Consistent understanding of community-based employment by stakeholders throughout Commonwealth to support Virginia's Employment First Initiative.

Benchmarks for Success: Tools and trainings that help stakeholders to have meaningful conversations that lead to employment; Increase capacity and competence of employment providers (school, CSB, ESO, etc.)

Activities: Revised Case Management training modules to align with new expectations and compliance indicators; developed resource materials for educators, CM's, and families to increase community engagement and employment opportunities; identifies the target audiences and their role in transition activities towards employment; and develops reference and access guides and fact sheets.

Outcome 3: Track and analyze existing and new data to increase employment opportunities for the targeted population.

Benchmarks for Success: Increased number of individuals are employed in competitive integrated employment.

Activities: Complete trend data report; develop baseline data for individuals, by age group, who received new waiver slots and who were subsequently employed; revise the data survey to improve information collected; assess capacity; and develop and implement a plan to address areas needing additional provider capacity.

Outcome 4: Development and implementation of best practices evidenced informed (IPS) Individual Placement Supports Pilot Program for the state of Virginia

Benchmark for Success: Policy recommendations that lead to increased employment; Best practice implementation guides; Communication materials for stakeholders

Activities: Develop best practices framework for supported employment; high needs supported employment; customized employment sustainability; and peer recovery supported employment.

Outcome 5: Assure an active and committed membership that will help advance the Employment First Initiative for all.

Benchmark for Success: Active member participation; Membership representative of all stakeholders

Activities: Review EFAG membership guidelines; convene membership group as needed; and review and insure active EFAG participation

Conclusion and Recommendations

Based on interviews and a review of the training materials it is evident that both DBHDS and the EFAG continue to be involved in the activities of the Employment First Project Plan, but that less has been accomplished or completed in this, than in the previous, reporting period. There continues to be involvement of other state agencies on the E1AG; and DBHDS has revised its comprehensive curriculum for CMs to address the expectations of ***CI 14.01***, as well as developed additional training materials. Progress has been made on the HNS project; CM employment training and related tools for CMs to use to further meaningful discussions; and tools to engage 14–17-year-olds in discussions and transition activities. Overall, progress to implement the Employment First Project Plan has stalled.

7.b.i.B.1.a-e: The Commonwealth is to develop an employment implementation plan to increase integrated day opportunities for individuals in the target population including supported employment, community volunteer activities, and other integrated day activities. The plan shall establish, for individuals receiving services through the HCBS waivers:

Annual baseline information regarding:

a. The number of individuals receiving supported employment.

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

c. The amount of earning from supported employment.

d. The number of individuals in pre-vocational services; and

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

DBHDS has worked in partnership with the DARS to refine its data collection since October 2014. DBHDS had a response rate of 100% from ESOs for several review periods. The DBHDS submitted two semiannual reports on employment for this reporting period which includes the entire eighteenth and half of the nineteenth periods. One summarizes December 2020 data and the other summarizes June 2021 data. The DBHDS Semiannual Draft Report on Employment dated 10/12/21 is the eleventh consecutive semiannual reporting period in which responses were received from 100% of the ESOs.

DBHDS continues to gather data from a second source for its employment reports. DBHDS used its data sharing agreement with DARS to gather data regarding individuals with developmental disabilities who receive employment support from DARS funded services including Extended Employment Services (EES) and Long-Term Employment Support Services (LTESS). The consistency of data reporting from both DARS and the ESOs make it possible to compare data between reporting periods.

Statewide Employment Data Analysis-This report compares the achievements in June 2020 to the achievements in employment in June 2021 to provide comparison over a full year. The data in ***Table 1*** below compares the employment data for individuals funded by DARS or an HCBS Waiver in June 2020 and June 2021.

Table 1: Comparison of the Number of Individuals in ISE and GSE in June 2020 and June 2021							
Funding Source	ISE Participants 0620	ISE Participants 0621	**ISE Change**	GSE Participants 0620	GSE Participants 0621	**GSE Change**	**Total Change of ISE and GSE**
Waiver	480	469	**-11**	235	239	**+4**	**-7**
EES	32	31	**-1**	25	23	**-2**	**-3**
LTESS	1865	1809	**-56**	45	15	**-30**	**-86**
Other	334	348	**+14**	250	159	**-91**	**-77**
DARS	249	414	**+165**	2	1	**-1**	**+164**
TOTAL	2960	3071	**+111**	557	437	**-120**	**-9**

The data indicates that between June 2020 and June 2021, there were increases in the number of individuals who were in Individual Supported Employment (ISE) services and decreases in the numbers in Group Supported Employment (GSE) services. A total of 3,508 individuals were employed as of June 2021 compared to 3,517 who were employed twelve months earlier. This is a decrease of only 9 individuals who were employed across ISE and GSE between June 2020 and June 2021, compared to the decrease of 814 individuals between June of 2019 and June of 2020. The time in early 2020 includes the first months of the COVID pandemic when many businesses and program closed. The increase of ISE participants is primarily in the DARS funded programs. There were small decreases for waiver and LTESS participants in ISE during this time period. There are decreases in GSE overall with the most significant decrease in the "Other" category. DBHDS explains that the decrease in participation in ISE waiver services is in part the result of how individuals re-engage in ISE after losing a job. If an individual was furloughed or laid off from a job during COVID and returned to the same job, the individual would continue ISE as a waiver service. If the individual lost a job and reengaged in a job search and job training s/he would first be supported through DARS. DBHDS reports that this will continue to impact the number of individuals in ISE and GSE waiver services in FY22.

As of June 2021, the numbers of individuals in these two situations changed when compared to June 2020, as follows:

- 111 more individuals were employed in ISE
- 120 fewer individuals were employed in GSE

These numbers reflect the total number reported as employed across all employment programs including the programs offered by DARS as well as the HCBS waiver employment services. This is the second time there has been an overall decrease in the number of individuals with I/DD employed in ISE and GSE since DBHDS has reported these data. In all likelihood this decrease was caused by the outbreak of the COVID 19 pandemic and its continued effects in Virginia and the nation which caused both short and long-term

unemployment for all workers including those with disabilities. It is somewhat heartening that some of the ISE jobs returned, although not for waiver participants. Virginia has strategically decided to limit GSE opportunities so the decreases in GSE may in part reflect this decision. However, it will be important to see a transition for individuals who previously were employed through GSE to have ISE support as the job market reopens in FY22, so these individuals have renewed opportunities to work.

It will be important to review the data in both of the next two semiannual reports which analyze data for December 2021 and June 2022 to determine if this becomes an unfortunate trend or if individuals in Virginia with disabilities recover or replace their jobs as the effects of the pandemic on employment lessen.

Overall, 3,508 people are employed with supports from ISE and GSE. The target set by the E1AG in 2015 was that 4,865 individuals would be employed representing 25% of the 19,461 individuals on the waiting list as of 6/30/21. The number actually employed, 3,508, represents 18% of the number of individuals either on a HCBS waiver or the waiver waiting list who are between the ages of 18 and 64. This is a slight decrease from June of 2020 when 19% of the target was met.

The data indicates that 708 individuals on the waivers are employed of 13,662 adults on the waiver between the ages of 18 and 64. This is 5% of individuals on the waiver. In June 2020, 715 individuals on the waivers were employed representing (5%) of the 14,563 individuals who are waiver participants. This is a decrease from the previous year when 1,078 individuals on the waiver were employed, representing (8%) of all 13,955 individuals on the waiver as of June 2019. Of the 708 individuals who were employed as of June 2021, 469 (66%) are employed through ISE and 239 (34%) are employed through GSE. These percentages are comparable to those in June 2020.

DBHDS sustained the accuracy and comprehensiveness of the employment data in terms of the overall number of individuals with disabilities who were employed. Once again 100% of the ESOs reported on the number of individuals employed who were waiver participants.

DBHDS continues, as it should, to report on the number of individuals employed in ISE and the number in GSE. The long-term goal of the Settlement Agreement, however, is to have individuals employed through ISE and eventually be competitively employed. Overall, of all of the individuals in supported employment in June 2021 in either ISE or GSE, 87% were employed in ISE, compared to 84% in June 2020; 75% in June 2019; and 73% in June 2018. The Commonwealth is continuing to make progress offering individualized employment opportunities for individuals with DD.

Again, the DARS LTESS program funds the majority of individuals in ISE. Of the total number of individuals in ISE, 15%, compared to 16% in June 2020 and 17% in June 2019 are participating in the HCBS waiver-funded employment services as of June 2021. Of individuals in HCBS waiver funded ISE, the number decreased by 11 individuals between June 2020 and June 2021. There had been increases in the number of ISE waiver participants from FY16 through FY19. During this most recent period, the number of

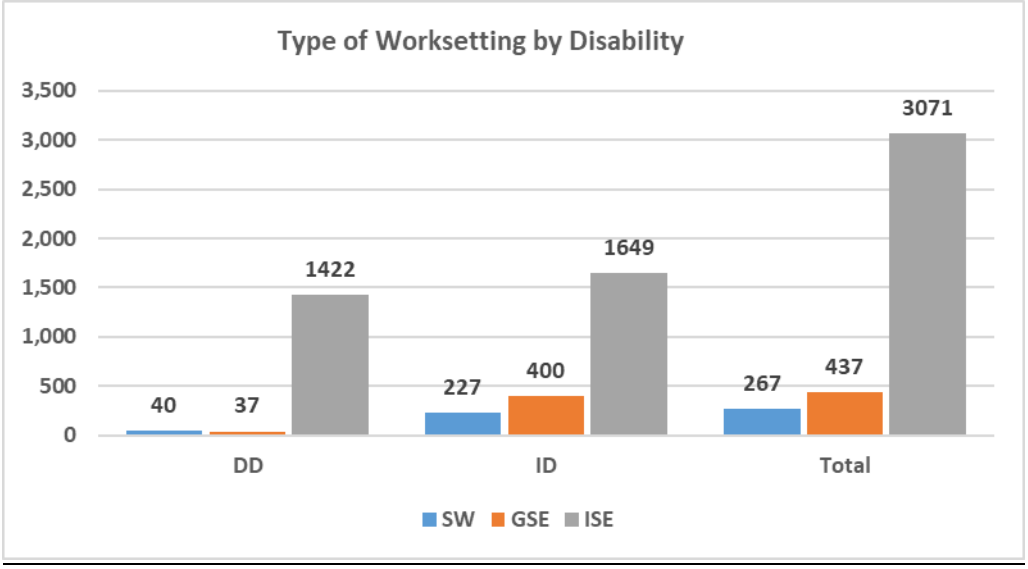
individuals in HCBS waiver funded GSE increased by 4 individuals. This is the first year in several years where an increase in GSE waiver participation occurred. The overall trend of decreasing GSE services continues as depicted in ***Table 1.***

The number of individuals in the sheltered workshops (SW) is not counted by DBHDS towards the employment target goals. However, it is important to track the changes in utilization of the workshops. Fewer individual should be in SWs as a result of the changes DBHDS made in the waiver service definitions. The Commonwealth did not plan to have SWs in the waiver at all by July 2019 to make sure Virginia was fully compliant with the federal Workforce Innovation and Opportunity Act (WIOA). Prior to 2021 the Commonwealth accomplished three years of decreases in the number of individuals in sheltered workshops overall and in the waiver program specifically. However, in June 2021 the participation in sheltered work increased from thirty-seven to forty-eight in waiver settings, and overall increased by seventeen from a total of 397 in sheltered work across all employment program funding sources to a total of 437 participants. This may be another impact of the COVID pandemic which decreased integrated and competitive employment opportunities for individuals with DD.

Employment of ID and DD individuals Overall there is a slight decrease in the numbers of individuals employed with either ID or DD between June 2020 and June 2021 which is reflective of previous data presented in this report. Of the individuals employed through ISE, 1,422 have a DD and 1649 have an ID. The percentage of individuals with DD compared to the percentage of individuals with ID who are employed shifted slightly between June 2019 and June 2020. In June 2019 33% of those with disabilities who were employed had DD and 67% had ID. In June 2020 these percentages changed to 37% and 63% respectively. There is a significant shift in these percentages between June 2020 and June 2021 when 46% of the individuals in ISE had DD and 54% of these individuals have ID. Between June 2020 and June 2021 the number of individuals with DD in ISE increased by 185, from 1237 to 1422 individuals, while the number of individuals with ID in GSE decreased from 1723 to 1649 over the same time period. Employment for individuals with DD increased by 15% while employment in ISE decreased for the individuals with ID by 4%. It would be valuable for DBHDS and the E1AG to review this data and compare it to future reporting periods to analyze if the impact of the pandemic has had disparate impact on the different disability groups in terms of the opportunities to return to gainful employment.

Graph 1 below shows the employment involvement of individuals by disability group: individuals with Intellectual Disabilities (ID) and those with Developmental Disabilities (DD), other than ID as of June 2021.

Graph 1: Type of Work by Disability Setting



The data in the graph above is from the DBHDS Semiannual Draft Report on Employment (June 2021 Data)

Average hours worked- The Commonwealth no longer reports on these data by ID and DD target groups. Previously individuals with DD worked more hours on average than did their counterparts with ID. Comparisons of both data sets have been useful in the past as they provide more detailed information about potential areas of underemployment and geographic disparities. **Graph 2** below details hours worked by service type in the DBHDS Semiannual Employment Draft Report as of June 2020.

There has been a decrease in the number of individuals who receive employment support whose wages are reported. The percentage of individuals who work twenty hours or less per week comparing the data from June 2021 to the data from June 2020 remains at 56% of the total number of individuals working. However, the percentage of individuals in GSE working twenty or fewer hours increased from 70% to 80% of the total number of individuals with I/DD working in GSE, while the percentage for individuals in ISE remained the same (54%) of all individuals with DD working in ISE. DBHDS reports that job sites for GSE decreased in this reporting period and GSE participants shared jobs so more individual could remain employed, thereby decreasing the number of hours various individuals were able to work

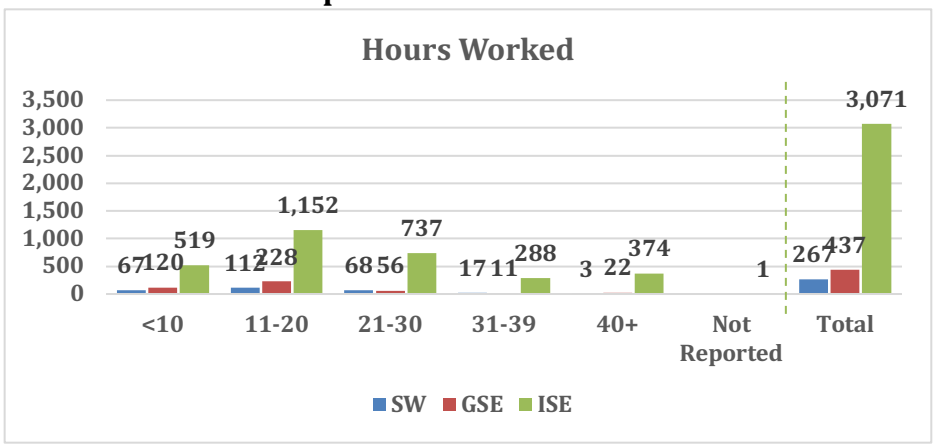
The percentage of individuals reported as working more than thirty hours per week in ISE decreased from 25% to 22% of the total number working in ISE; and decreased from 16% to 8% in GSE comparing data in June 2020 to data in June 2021. Also, the number of

individuals in ISE working either 31-39 or forty or more hours per week decreased by thirteen individuals in the nineteenth reporting period. DBHDS still does not report on whether individuals are working the number of hours they want to be employed. Many of the individuals may be underemployed.

This is determined based on the fact that 54% (1,671 of 3,071 individuals in ISE) are working no more than twenty hours per week. This overall percentage remains consistent with the data from previous reporting periods.

The data below depicts the hours worked by service type as of June 2021

Graph 2: Hours Worked

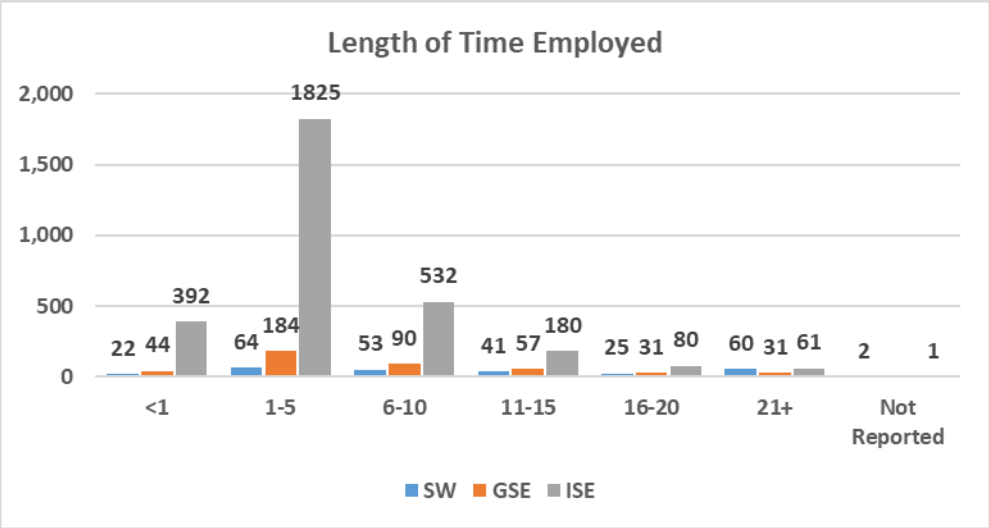


The above graph is from the DBHDS Semiannual Employment Report draft June 2021

DBHDS now reports the type of employment services individuals receive by age. This graph was added in 2020 so that the E1AG could monitor transition age youth and the employment choices they are making with the initiation of the Workforce Innovation and Opportunity Act. Of the 3,071 individuals in ISE as of June 2021, 626 (20%) are between the ages of 18 and 24.

Average length of time at current job- these data are no longer specific to disability group, and therefore, reviewers cannot compare the length of time individuals with ID versus DD maintain a job. The expectation is that 85% of individuals will hold their jobs for at least twelve months**.** ***Graph 3: Length of Time Employed*** below depicts the data as of June 2021. Overall, 88% of all individuals employed worked at their job for one year or more. This is reflective that 87% of individuals in ISE held their jobs for twelve months or more compared to 86% in June 2020; and 90% of individuals in GSE in June 2021, compared to 90% of individuals in GSE in June 2020 were employed in their job for more than twelve months. However, the data do not account for all of the individuals who lost their jobs during the pandemic and who have not returned.

Graph 3: Length of Time Employed



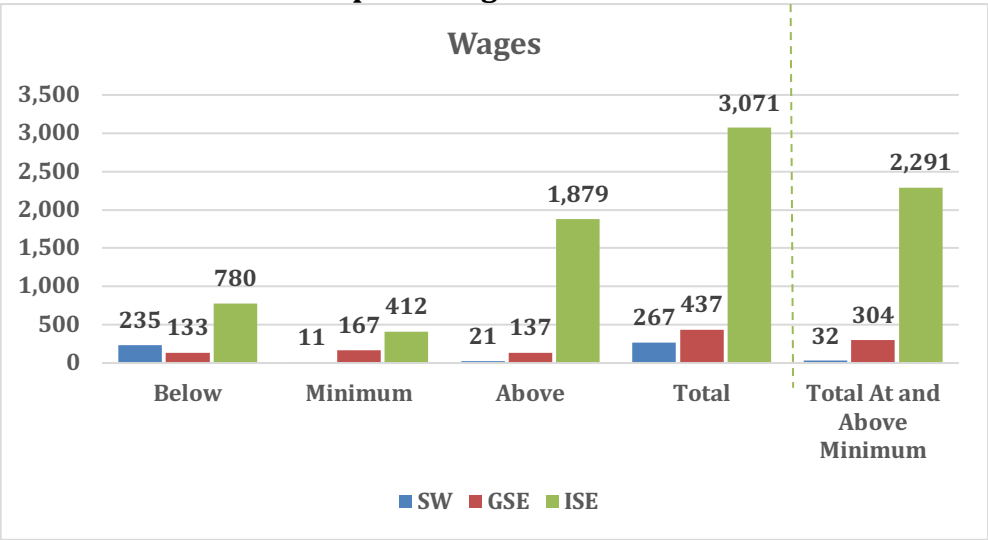
The above graph is from the DBHDS Semiannual Employment Report draft June 2021

Earnings from wages- DBHDS collected information regarding wages and earnings. ***Graph 4 Wages*** below depicts the number of individuals that earn above or below minimum wage by employment program type for June 2021. Wages have dropped significantly if this data is accurate. DBHDS notes it may reflect reporting errors regarding individuals earning less than minimum wage because of the minimum wage increase in Virginia effective May 1, 2021. This data indicates as of June 2021, 133 individuals in GSE and 780 individuals in ISE were earning less than minimum wage. This is a substantial increase from June 2020 when all but nine individuals in ISE earn at least minimum wage and the number of individuals in GSE, earning less than minimum wage was 61. In the mid-year semiannual draft report depicting December 2020 data, only 10 GSE and 4 ISE participants were reported making less than minimum wage.

Overall, 74% of individuals working in either ISE or GSE make at least minimum wage, compared to 98% on June 2020. The wages paid to individuals in ISE range from $5.25 (plus tips) to $80.00. The highest salary is a significant increase over the $60.00 highest hourly wage in June 2020. In GSE the range of wages paid was $0.23-$17.96. Both the lowest and highest hourly wage in GSE decreased from June 2020

when the range was $0.32-$23.00. It is troubling that 26% of the individuals employed through GSE and ISE are reported as making less than minimum wage throughout all of the employment programs in Virginia for individuals with DD.
The graph below depicts this data

Graph 4: Wages



The above graph is from the DBHDS Semiannual Employment Report draft June 2021

Conclusion and Recommendations: The DBHDS continues to report on the expectations set forth in *7.b.i.B.1.a, b, c, d, and e.* Its data reflects information from 100% of all providers including the providers who offer HCBS waiver funded services and all employment related data from DARS relevant to the I/DD population. It is concerning that wages have decreased as have the average number of hours individual shave the opportunity to work.

VII. Setting Employment Targets

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

DBHDS has set employment targets at two levels. A target was set on December 30, 2015, for 25% of the total number of individuals with I/DD 18-64 years old on the waivers or the waiting list (16,871), to be employed, in both ISE and GSE, by June 30, 2019, for a total of 4,218 individuals. This target was revised to reflect the total number of individuals with DD on the waivers or waiver waiting list as of 6/30/20, which was 18,621. The number of individuals on the waiver or waiting lists has increased to 19,461 as of June 2021. Therefore, the Commonwealth commits to a total of 4,865 being employed as of June 30, 2021. However, the total number employed through ISE and GSE was 3,508 as of that date, representing 18% of the total number on the waivers or waiting lists. There were 3,517 individuals employed through ISE and GSE combined as of June,2020, representing 19% of

the waiver and waiting list number. There were 4,331 individuals employed in either GSE or ISE as of June 30, 2019, which represented 24% of the waiver and waiting list number. There has been a steady decline in the Commonwealth's achievement of the target which is in large part attributable to COVID. It is noteworthy that the numbers of individuals employed in June 2021 increased by 312 when compared to December of 2020. But the number employed in June 2020 (3517) is comparable to June 2021 (3508). The vaccine was available in early 2021 making it possible for more individuals with I/DD to returned to work. However in Virginia, providers and some businesses remained closed and some families remained reluctant for their adult children with I/DD to return to employment programs or to work settings.

The second goal is to increase the number of individuals who are employed through waiver programs. DBHDS set employment targets for this goal several years ago. These targets are depicted in ***Table 2*** below. DBHDS reversed its progress toward the employment targets it has adopted for increases in employment for individuals in the HCBS waiver in FY19, prior to the beginning of the pandemic in 2020. DBHDS reduced the target in FY19 from 1661 to 1211. DBHDS projected in FY19 that it would take until FY21 to achieve a target of 1685, close in number to the original FY19 target. However, the Commonwealth is not close to achieving that target as explained in the following paragraph.

Table 3 depicts the overall employment changes in waiver programs from FY16- FY21. In the past five years an additional 244 individuals are employed in ISE programs. There is an overall decrease in the number of individuals employed in waiver programs of 182 because of a significant decrease in the number of individuals employed through GSE. The target for FY21 was to have 1685 individuals employed including 1135 in ISE and 550 in GSE. Instead, there are only 708 individuals employed through HCBS waiver employment programs including 469 individuals in ISE and 239 individuals in GSE. DBHDS has been set back during this reporting period reaching only 42% of the target it set for the end of FY21. In comparison, DBHDS had reached 48% of the target at the end of FY20. A total of 363 fewer waiver recipients were employed as of June 2020 compared to waiver recipients who were employed as of June 2019. This decrease includes 75 individuals in ISE and 288 in GSE. The decrease has continued in FY21 but is significantly reduced. Seven fewer individuals were in ISE and GSE waiver programs in June 2021 compared to June 2020. There were 11 fewer in ISE and 4 additional individuals in GSE.

Again, it seems somewhat surprising that there was not more incremental positive change between June 2020 during the height of COVID and employment restrictions and June 2021.

DBHDS in consultation with the E1AG in FY19, extended its employment initiative by an additional year to FY21 but targets 341 fewer individuals to be employed using waiver programs, reducing the target of the number to be employed from 1218 to 877. DBHDS' explanation for the changes in employment targets for the waiver program is that the original targets were mere projections not based on proven efforts. In FY19 the E1AG and DBHDS engaged in a review of employment trends and based new targets on those trends reflected in FY16-FY18 data, and to account for the initiation of Community Engagement (CE). The reduced employment targets have not been reached. CE continues to not

increase at its previous rate and will be discussed later in this report. Also, all individuals should have an opportunity to be employed and engage in non-work community activities during other parts of the day and week, rather than have CE substitute for meaningful employment.

Table 2 illustrates and compares the original targets to the revised targets set in 2019 and reflected in the June 2021 report as the continued targets set by the Commonwealth.

Table 2: Employment Targets for the HCBS Waiver Programs FY16-21						
End of FY	**ISE**	**ISE (new)**	**GSE**	**GSE (new)**	**Total**	**Total (new)**
16	211		597		808	
17	301		631		932	
18	566		731		1297	
19	830	**661**	831	**550**	1661	**1211**
20	1095	**936**	931	**550**	2026	**1486**
21	NP	**1135**	NP	**550**	1685	**1685**
Total Increase '16-'21	*884*	***924***	*334*	***(-47)***	*1218*	***877***

Table 3 below depicts that actual change in the number of individuals employed in the HCBS waiver programs from FY16 to FY21.

Table 3: Number of Individuals Employed in the HCBS Waiver Programs FY16-21			
End of FY	**ISE**	**GSE**	**Total**
16	225	665	890
17	305	521	826
18	422	550	972
19	555	523	1078
20	480	235	715
21	469	239	708
Total Increase '16-'21	***+244***	***(-426)***	***(-182)***

Comparison of the Targets- As of June 2021 neither of the targets set for employment have been met. There have been significant reductions as a result of COVID, but the Commonwealth had not met it targets in FY19 either. As of June 2019, Virginia was much closer to achieving its overall employment goal of 25% of all waiver participants and waiting list individuals being employed when it achieved employment for 24% of this group across all employment programs for individuals with I/DD. In June 2020 this percentage dropped to 19% of individuals on HCBS waivers or waiting lists and dropped further to 16% of this group in June 2021.

More significantly the Commonwealth has not met the target for employment for individuals with waiver-funded services as its population of individuals with I/DD has experienced reductions in employment.

There is a table in the Semiannual Employment Report that captures the number of unique individuals who have a service authorization for each day service in the waiver including ISE and GSE. This information is included in this report in ***Table 4*** on page 25 and is more fully discussed later in this report regarding community engagement.

The number of individuals *authorized* for ISE and GSE differ from the number of individuals *participating* in ISE and GSE. In June 2020, 953 ISE and 519 GSE authorizations were awarded versus 480 ISE and 235 GSE actual participants (data from ***Table 3***). The number of authorizations versus the number of actual participants in 2021 follows a similar pattern: 704 ISE authorizations versus 469 participants, and 310 GSE authorizations versus 239 GSE participants. Both authorization numbers are higher than the number reported as actually employed through waiver ISE and GSE services, which is understandable as many individuals may still be assisted finding a job, and the availability of jobs has decreased during the pandemic. It is noteworthy that Virginia continues to make a significant financial commitment to employment for individuals on the HCBS waivers. The authorizations for ISE decreased by 249 between June 2020 and June 2021, from 953 to 704 authorizations. The ISE and GSE authorizations did not closely match the waiver employment targets. The ISE target for FY21 was 1135 and there are 953 authorizations. The GSE authorization of 249 is significantly less than the target of 550 set for FY20. It is understandable that individuals with I/DD were not employed in FY20 and FY21 at the same levels as previously due to COVID. DBHDS reports it authorized far fewer ISE and GSE opportunities, even in FY21 because many businesses were not reopened, and providers remained closed.

CE was designed to provide inclusive community options for individuals who were not ready or interested in employment and to enhance the lives of individuals with part time employment. It was not intended to replace employment for individuals capable of and interested in working. This data will need further analysis in future reporting periods to determine if there are trends and unintended consequences on employment growth by offering this new service option.

In order for the Commonwealth to reach its employment targets in future fiscal years, especially in ISE for individuals in the HCBS waivers, the DBHDS will need to concentrate on increasing provider capacity and ensure CMs are adequately trained to discuss

employment in a meaningful way and are aware of all of the resources to make available to individuals and families. Virginia's plan to provide training and technical assistance to providers to offer employment support to individuals with more significant disabilities should prove helpful to increase the number of waiver participants who are employed. Later in this report I will discuss the themes from the qualitative study in which 100 individuals' ISPs were reviewed to determine if Case Managers held meaningful employment discussions and set employment goals for individuals interested in employment. As a result of reviewing these ISPs and interviewing case managers it is evident that families need much more information about employment and particularly its impact on individuals' benefits; case managers need training to assist individuals with behavioral, medical or physical needs to feel more confident exploring employment, and DBHDS and CSBs need to address the barrier of transportation if the number of individuals employed is to increase in any significant way. These are similar themes to those discussed in the last Expert Reviewer's report.

Conclusions and Recommendations: The Commonwealth has not met the target it set for the percentage of individuals with I/DD who would be employed by 2021 across all of the DARS and DBHDS waiver employment programs which responds to ***CI 14.09.*** The Commonwealth reduced its targets to meaningfully increase the number of individuals receiving services through the waivers in 2019. These revised targets have not been achieved as of June 2021. The Commonwealth has not met ***CI 14.08*** because the number of individuals in waiver employment services is not within 10% of the target goal.

DBHDS did not include recommendations in the Semiannual Employment Report draft based on June 2021 data, nor did DBHDS make recommendations based on the findings in the June 2020 report. However, many of the recommendations made in June 2019 remain relevant to achieving these targets. It is clear that DBHDS has been consumed with activities related to maintain the health and safety of individuals during the COVID pandemic and addressing the needs of providers during this period.

Work on strategic planning and activities have seemingly halted during this period based on interviews with DBHDs staff, E1AG members and reviewing the lack of progress made by the E1AG during this reporting period. While it is understandable that administrative attention was diverted to address the very real implications of the pandemic, the Commonwealth must return to its efforts to undertake relevant data analysis and use it to make strategic decisions to get both employment and community engagement efforts to a point of success. Relevant recommendations were made in FY19 that have yet to be implemented. Continued efforts to fully implement these recommendations would further DBHDS's efforts to achieve its employment goals. These include:

1. *DBHDS needs to continue collaborating with CSBs to ensure that accurate information about the different employment options is discussed with individuals in the target population and that these discussions are documented.*
    a. *Work with the E1AG to develop a video that shows the conversation between a case manager and individual and their family to show how to have a better conversation. (not done but discussed)*

2. *Increase the capacity of the Commonwealth's provider community to provide Individual Supported Employment services to persons with intellectual and developmental disabilities by providing technical assistance and training to existing and potential new providers.*
    a. *Report the number of waiver providers offering Individual Supported Employment and Group Supported Employment*
    b. *Training for providers to support people with more significant disabilities.*
    c. *Competency development*
    d. *Find out from ESO's additional services offered/subcontracted to identify potential combination of services that would help providers be better able to support people with specialized needs.*
3. *Increase capacity in parts of the Commonwealth that have less providers and employment options. Create a map of the service providers in each of the Regions and the services provided so we can track increase in capacity.*
4. *Do a comparison in future reports of employment discussions and employment goals to evaluate the impact on the percent of people employed per region.*
    a. *DBHDS will follow up with the CSBs who have data reporting concerns around the discussion of employment and goals to address barriers to employment.*
5. *Create data tables around the waiver data according to old slots, new slots, and training center slots.*
6. *Implement recommendations from the Regional Quality Councils.*
    a. *Develop tools/training for individuals and families by using the trend reports for targeted training*
    b. *Gather transportation data*
    c. *Improve communication with DOE around transition age youth and employment services and supports. (No update.)*
7. *Monitor the number of transition age youth entering non-integrated work settings to determine potential future intervention.*

I continue to recommend that the Commonwealth further refine these targets by indicating the number of individuals it hopes to provide ISE to from the following groups: individuals currently participating in GSE or pre-vocational programs; and individuals newly enrolled in the waivers during the implementation of the Settlement Agreement. I am pleased that the E1AG has also made this recommendation, however the analysis has not been undertaken yet, over three years since the E1AG made the recommendation.

Creating these sub-groups with specific goals for increased employment for each will assist DBHDS to set measurable and achievable goals within the overall target and make the undertaking more manageable and strategic. Realistic and successful marketing and training approaches to target these specific groups can be developed through discussions between the DBHDS and the E1AG. A collaborative outreach effort to families, case

managers, CSBs, Training Center staff, and ESOs will assist the DBHDS to achieve its overall targets in the next fiscal year.

VIII. The Plan for Increasing Opportunities for Integrated Day Activities

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

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

The Integrated Day Activity Plan states that foundation for community engagement is included in the HCBS waiver as redesigned to offer community engagement, community coaching, and related services with reasonable rates.

DBHDS, with the input of the Community Engagement Advisory Group (CEAG), drafted a comprehensive Community Inclusion Policy several years ago. This policy sets the direction and clarifies the values of community inclusion for all individuals with intellectual and developmental disabilities, regardless of the severity. The policy requires the involvement of both the DBHDS and the CSBs:

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

Implementation requires DBHDS to provide training and consultation; to work with DMAS to incorporate these services in the waivers; to develop an implementation plan; and to maintain membership in the national SELN. The CEAG has been disbanded as the work of this group was considered completed by DBHDS. The Community Engagement Plan had six goals that are considered to be completed so there was no reporting for this review period or the seventeenth review period. As reported below Virginia has lost ground providing CE and CC services. It may be useful to reestablish the CEAG. It became apparent during this review process that DBHDS intends to bring the CEAG members back together to advise the department on its efforts to increase meaningful community involvement for individuals with I/DD.

Individuals Participating in Day Service Options

DBHDS has provided data, which is depicted in **Table 4** below that allows for comparison and growth of Community Engagement (CE) and Community Coaching (CC) from 6/30/19 through 6/30/21. This information reflects the number of individuals authorized for each service type.

Table 4: Individuals Authorized for Day Services 6/30/19-6/30/21							
Date	**Group**	**CC**	**CE**	**ISE**	**GSE**	**WA**	**Total**
06/30/19	**6545**	**283**	**2650**	**789**	**552**	**69**	**10,888**
06/30/20	**6511**	**295**	**2572**	**953**	**513**	**72**	**10,916**
06/30/21	**5312**	**259**	**2123**	**704**	**310**	**49**	**8,757**
Change	**-1233**	**-24**	**-527**	**-85**	**-242**	**-20**	**-2131**

In the twelve- month period, 6/30/20 to 6/30/21, there was a decrease of 36 individuals authorized for CC, compared to an increase of 12 in the previous twelve-month period. The authorization for individuals in CE decreased by 449 individuals compared to a decrease of 78 in the previous twelve months. Group day services also experienced a reduction in its authorizations from 6511 in June 2020 to 5312 in June 2021, a decrease of 1,199 in the twelve-month period. ISE as reported previously increased dramatically in June 2020 from 789 in June 2019 to 953 in June 2020, but then decreases to 704 in June 2021. There are significant decreases in all service authorizations between 6/30/19 and 6/30/21. These reductions equal 19% in Group Day; 8% in CC; 20% in CE; 11% in ISE; 44% in GSE; and 29% in Workplace Assistance. The reductions in Group Day could be evidence of the Commonwealth's shift to CE and employment but there are reductions in those authorizations as well which is disheartening. ISE is of particular concern. While its overall decrease in the two-year period is 11% it had increased significantly between FY19 and FY20 by 164. The percentage decrease between the authorizations in FY20 and FY21 was much higher totaling a 26% reduction in ISE authorizations.

These employment and day support programs had 8,757 individuals authorized as of 6/30/21 compared to 10,888 and 10,916 of 6/30/19 and 6/30/20, respectively. This is a very significant and troubling decrease in service authorizations. DBHDS is strategically trying to increase participation in IDA services including employment and community engagement services. When you remove the group day data and analyze the decreases in authorizations in the IDA related services you discover a decrease of 898 individuals between FY19 and FY21. This is a 21% decrease which is significant. DBHDS reports that the decreases between June 2020 and June 2021 were in great part the result of programs and employment ending or continuing to be suspended because of COVID. DBHDS extended individuals' service authorizations in FY20 during COVID, but could not continue the authorizations in FY22 when a new ISP was created if the service was not actually available to the individual. DBHDS administrators report that it is simple for waiver services to be reauthorized.

The percentage of individuals authorized for CC, CS, GSE, ISE and Workplace Assistance remained 39% of the individuals authorized for some type of day support service in June 2021, which is similar to June 2020 and June 2019 when the percentage was 40%. While DBHDS produces data that allows for a comparison of individuals actually participating in GSE and ISE to the numbers authorized for ISE and GSE, similar data are not provided for CC and CE. DBHDS does not report on the actual number of individuals enrolled in a CC or CE service. This would be particularly valuable data to have and analyze because it appears from the two qualitative studies completed by the Expert Reviewer in 2019 and 2020 that there was insufficient capacity of CE providers. This was not analyzed in 2021 because Case Managers were not interviewed, and this data was not provided by DBHDS.

***Conclusion and Recommendations**:* The DBHDS and the CEAG have developed a robust definition of Community Engagement. These services have been approved by CMS and offered to waiver participants since September 2016. There is a total of 8,757 individuals authorized for waiver day services including center-based day services. The percentage of authorized services for integrated day settings is not increasing in comparison to the number of authorizations for Group Day congregate settings. Also, the decrease of 2,131 (20%) of individuals authorized for any day service is startling, and the decrease in authorizations of 898 (21%) for IDA services is of more concern.

As of June 2020, 2,867 of these individuals are authorized for CE and Community Coaching (CC) compared to 2,382 in June 2021.This is 485 fewer individuals who have these authorizations. The percentage of participants compared to the percentage in center-based day settings has not grown in the past year. It is evident from the qualitative employment study of 100 individuals during the two previous reporting periods that there is not a sufficient number of CE providers, and that there is a significant dearth of these services in some parts of the Commonwealth. DBHDs reports this year that there are continuing concerns among providers about the viability of providing CE within the current rate structure. DBHDS reports that it plans to introduce the need for increased rates for CC and CE in the upcoming agency budget preparation for FY23.

DBHDS continues to support residential service providers to also provide CE services. These providers may be more suited to match individual interests and support meaningful community participation for individuals after work and on weekends, when more typical adults are also involved in community activities. From the records reviewed in the IDA Qualitative Study it is also apparent that some personal assistance and consumer-directed support providers are assisting individuals to experience integrated community activities. DBHDS staff who were interviewed spoke about the relevance of capturing community integration that occurs through natural supports when determining the extent of the involvement of individuals in community activities recognizing the opportunities for community inclusion can happen outside of a CE service. It will be important for DBHDS to capture this data and reflect it in reporting on community engagement outcomes.

However, I caution DBHDS to ensure that CMs clearly understand and can demonstrate competence in recognizing what comprises true community inclusion before either CSB or CQI reports include any of this data as evidence of individuals experiencing community involvement outside of actual CE and CC services. We found that many CMs do not

demonstrate this understanding when we reviewed the 100 records in the sample for the IDA Study. Our study found that many CMs inappropriately report that individuals who attend group day services in congregate settings participate in community engagement because they go into the community as part of a group of disabled individuals for a very small portion of each week. This is discussed in greater detail in the IDA Study report. DBHDS has provided excellent definitions of CE and CC services and have included them as part of a robust menu of HCBS waiver services. DBHDS places an important value on these services and also views them as supports that can assist individuals to be more prepared to work. DBHDS should not dilute their mission to provide these services as meaningful alternatives to non-integrated day service options.

I continue to recommend that DBHDS produce quarterly reports summarizing demographic data, successes, barriers and the average hours of participation in CE and community coaching by urban and rural areas. These reports have not been produced but would be extremely useful in helping DBHDS determine how best to increase participation in CE and encourage more providers to offer CE. I recommend that DBHDS initiate this during the next reporting period so there are specific data to better determine the success of this initiative longitudinally. CE is failing as indicated by the significant drop in service authorizations this year which equaled a 21% reduction. Given the retrenchment of these services and the demonstrated lack of understanding by CMs of the importance and value of these services, it seems important to re-establish the CEAG. I am encouraged that DBHDS recognizes this need and reports that is planning to reconvene the group later this fall. Data about provider capacity and the impact of rates on CE should be gathered and analyzed by the CEAG. There has been an overall increase of 12.5% for HCBS waiver services for FY22 and DBHDS is analyzing whether rates for various HCBS services need to increase permanently. The CEAG could assist the DBHDS to decide how to adjust rates if needed to meaningfully increase CE availability and subsequently participation.

During this review period DBHDS decreased the number of authorizations of community engagement services for the second consecutive year, and for the first time in community coaching. In addition, it does not appear from the IDA studies that were conducted in 2019, 2020 and 2021 that CMs are well prepared to discuss CE options with individuals and families, nor may there be sufficient providers to offer CE. This is unfortunate because many individuals now in Group Day settings may switch from congregate based day programs to CE if it was available within a reasonable distance and if the benefits were well-explained and understood.

There appears to be a compelling need to further education of Case Managers to explain CE to individuals and families and to help address any barriers to the participation of the individual. DBHDS also needs to assure there is a sufficient number of providers in all regions, so families do not find the travel time to be a deterrent to the participation of their sons or daughters in CE when compared with congregate day support programs. I support the DBHDS plan to further engage residential providers in offering CE and CC. I again suggest the Commonwealth develops targets for CE as it does for employment; articulate

its expectations for hours of participation; and monitor the provision of these services to assure they are meaningful for the individuals. These issues are addressed in greater detail in the IDA Study. The issues of reductions in CE service authorizations; CMs apparent lack of a full understanding of CE services; and a lack of interest among families and individuals as evidenced by the IDA Study are further evidence of the need for a leadership group such as the CEAG at the state level to be reinstated.

The Commonwealth does not meet the applicable compliance indicators for III.C.7.a. (which also serve to measure III.C.7.b.) in light of two years of significant decreases in authorizations for IDA services including supported employment.

Compliance Indicator 14.10 requires that DBHDS continues to demonstrate an increase of 3.5% service authorizations annually being served in the most integrated settings as defined in the Integrated Employment and Day Services Report (an increase of about 500 individuals each year as counted by the unduplicated number of recipients).

Table 5 extracts data from the DBHDS Semiannual Draft Report on Employment (June 2021 Data) produced 10/12/21 for only those day services that are considered integrated day service options. This excludes Group Day. It indicates that there were decreases in the number of service authorizations for participants in the programs considered Integrated Employment and Day Services as discussed above. These service authorizations decreased between June 2020 and June 2021 as follows: Community Coaching (CC) which increased by 36; Community Engagement (CE) which decreased by 449; ISE which increased by 249; and GSE which decreased by 203. Workplace Assistance (WA) increased by 23 individuals. While these are for service authorizations, the data do not actually indicate how many of these individuals have initiated these services and are actually receiving them. The data provided in a different section of the DBHDS Semiannual Draft Report on Employment (June 2021 Data) indicates that of the 704 individuals authorized for HCBS waiver ISE, only 469 are receiving this service. Similarly, fewer individuals authorized for GSE are yet to receive GSE: 310 are authorized but only 239 were receiving it as of June 2021.

DBHDS does not report on the number of individuals receiving WA, CC or CE, just the number who have authorizations for these services. Without this data compliance with this indicator cannot be determined. However, since there were reductions in authorizations in all of the categories, and the overall change in service authorizations between June 2020 and June 2021 was a decrease of 960 (22%) of the 4,405 individuals who had authorizations in June 2020 compared to the 3,445 who had authorizations for an integrated day setting in June 2021, the Commonwealth does not appear to be in compliance as of this reporting period. DBHDS will need to report on the actual numbers of individuals receiving CE, CC and WA in future reporting periods for this indicator to be thoroughly analyzed.

Table 5: Individuals Authorized for Integrated Day Service Options 6/30/20-6/30/21						
Date	**CC**	**CE**	**ISE**	**GSE**	**WA**	**Total**
06/30/20	**295**	**2572**	**953**	**513**	**72**	**4,405**
06/30/21	**259**	**2123**	**704**	**310**	**49**	**3,445**
Change	**-36**	**-449**	**-249**	**-203**	**-23**	**-960**

The Commonwealth has not met the requirements of Compliance Indicator 14.10.

IX. Review of the SELN and the Inclusion of Employment in the Person-Centered ISP Planning Process

III.C.7.b. The Commonwealth shall:

- ✓ *Maintain its membership in the SELN established by NASDDDS.*
- ✓ *Establish a state policy on Employment First (EF) for this target population and include a term in the CSB Performance Contract requiring application of this policy.*
- ✓ *The principles of the Employment First Policy include offering employment as the first and priority service option; providing integrated work settings that pay individuals minimum wage; discussing employment options with individuals through the person-centered planning process at least annually.*
- ✓ *Employ at least one Employment Services Coordinator to monitor the implementation of the employment first practices.*

Virginia has maintained its membership in the SELN and issued a policy on Employment First. DBHDS hired an Employment Services Coordinator in the late fall of 2019 after this position was vacant since February 2019 and continues to have an Employment Services Coordinator.

The Settlement Agreement requires the Commonwealth to ensure that individuals in the target population are offered employment as the first day service option. DBHDS included this requirement expectation in its Performance Contracts with the CSBs starting in FY15.

The CSB Performance Contract requires the CSBs to monitor and collect data and report on these performance measures:

I.C. The number of employment aged adults receiving case management services from the CSB whose case manager discussed integrated, community-based employment with them during their annual ISP meeting, and

I.D. The percentage of employment-aged adults in the DOJ Settlement Agreement population whose ISP included employment-related or employment-readiness goals.

The Parties have agreed and the Court has approved specific Compliance Indicators in this area. Compliance Indicator 14.02 requires that employment discussions are held with 86%

of individuals in waiver programs and compliance indicator 14.03 expects that employment goals are included in the ISPs for 50% of these individuals who are age18-64.

Employment Discussion with Individuals- DBHDS reports that a total of 10,113 adults' case managers conducted annual ISP meetings or updates between July 1, 2020, and June 30, 2021. However, there are 13,662 individuals between the ages of 18-64 on a HCBS waiver who have a CM and an annual ISP meeting. The DBHDS report from the CSBs reflects data from ISP meeting for 74% of the total number of adults on one of the HCBS waivers. Of these 10,113 individuals, their case managers checked a box that indicated that a total of 9,792 individuals had discussed integrated, community-based employment during their annual ISP meetings. This indicates that 97% of the individuals who had an ISP meeting conducted discussed employment at some level, compared to 94% as of the previous report. DBHDS has not met the compliance indicator (37.07) requirement to determine the reliability and validity of these data before providing them for compliance reporting.

In June 2021, nine (22%) of the CSBs report that CMs had employment conversations with all of their waiver participants, which is an increase achieving 100% compared to the previous reporting periods. The number of CSBs reporting these employment conversations with at least 90% of individuals increased from thirty-one f to thirty-six or a total of 90% of all CSBs.

The following table, ***Table 6***, provides a breakdown of the percentage of individuals by CSB who were reported to be engaged in an employment discussion.

Table 6: A Comparison of Employment Conversations 2018-2021

% of Employment Discussion	Number of CSBs June 2019	Number of CSBs June 2020	Number of CSBs June 2021
100%	6	8	9
90-99%	22	23	27
80-89%	7	5	2
70-79%	1	2	1
60-69%	2	0	0
50-59%	1	1	0
40-49%	0	0	1
30-39%	0	0	0
20-29%	0	1	0
10-19%	1	0	0
0%	0	0	0

All but two of the CSBs recorded employment discussions for at least 86% of the adults who had an ISP meeting in the review period.

A total of 2,846 of the 10,113 individuals in June 2021 who had ISP meetings compared to 2,937 of the 9,805 individuals in June of 2020 have employment or employment related goals in their ISP. This results in a statewide average of 28% of individuals who had an annual ISP review in this reporting period who have an employment or an employment-related goal in their ISP. This is a decrease when compared to 30% in June 2020. None of the CSBs met the target of setting employment goals for at least 50% of adult on the HCBS waivers. Five CSBs record goals set for at least 40% of the adults on their caseloads who had ISP meeting in the review period.

The DBHDS has focused on improving the accuracy of the reporting. During the seventeenth reporting period DBHDs also established a record review process to monitor if the employment discussions occur, and employment goals are established for individuals in their plans. This was done through its Support Coordinator Quality Review (SCQR) process in which CSB supervisors and DBHDS Quality Improvement staff review 400 and 100 records respectively, that were randomly selected. Definitions of what DBHDs expects to see in a record to document if a discussion occurred were developed and shared with the reviewers for this study. A process of inter-rater reliability was designed for the reviews conducted by the DBHDS QI reviewers. We interviewed Britton Welch and Christine Lambert who led this process for DBHDS. The process they follow is quite thorough, but DBHDS has not made the required determinations that these data are reliable and valid and available for compliance reporting. DBHDS reports that it does not rely on these findings to support compliance reporting related to ***CIs 14.02, 14.03, 14.05 or 14.06.*** Instead, it relies on the self-reporting of the CSBs and that it has not verified the accuracy of these data for this reporting period. DBHDS did submit a Monitoring Questionnaire for Data Verification for these CIs (and for ***14.07 and 14.08***) that is being used starting with FY22 data. During the next reporting period, the DBHDS determinations that data it provides for compliance reporting will be reviewed.

However, I find it important to note the criteria being used in the SCQR process to determine if there is a meaningful discussion of both employment and of CE appears to be inadequate as discussed below. This is particularly concerning because it may reflect what the CSBs are using to verify the data they self-report to DBHDS. Our IDA qualitative study this period found that the CSB data are very likely not be reliable or valid yet are being provided by the Commonwealth for compliance reporting.

The DBHDS SCQR tool includes questions about employment and CE under the "All Other Questions" section, which are not related to measurable compliance indicators and not sufficient to provide its records "to document the requirements of the SA are being implemented" (as required by 54.01.)

For example, the SCQR Survey Instrument and Technical Guidance provides the following guidance to answer Q42: Is there evidence in the record that the CM discussed options for employment?

"To indicate a Yes answer, there must be clear documentation in the ISP Essential Information under "Summarize employment conversation and how barriers will be addressed as applicable" that confirms discussion of ***one or more*** of the following topics:

- employment interests
- available options
- satisfaction or dissatisfaction with current employment
- barriers related to pursuing employment options, addressing barriers
- a timeline for reviewing options in the future, at least annually, and/or
- any related actions that will be taken

Q50: Is there evidence in the record that the CM discussed options for integrated community involvement/CE/CC?

"To indicate a Yes answer, there must be clear documentation in the ISP Essential Information under "Summarize employment conversation and how barriers will be addresses as applicable" that confirms discussion of ***one or more*** of the following topics:

- community interests
- available community options
- satisfaction or dissatisfaction with current services
- barriers related to being involved with other community members, and addressing barriers
- a timeline for reviewing options in the future, at least annually, and/or
- any related actions that will be taken
- what the person is working on at home and school that will lead to more community participation and inclusion, and/or
- alternate sources of funding

It is deeply concerning that the DBHDS SCQR process allows for a conclusion of Yes and a finding of Met if only one of the above criteria for either an employment or CE discussion is present. One of these would rarely be sufficient to indicate there was a meaningful conversation, certainly not satisfaction; identification of barriers; or a timeline for future review, independent of discussing an individual's interests and providing an explanation of the services and service options. This use of sole criterion does not materially reflect the training that DBHDS provides to CMs as to what the department expects that comprises a meaningful discussion.

The ***Compliance Indicators 14.03 and 14.06*** expect that goals for employment and CE, respectively will be set. The SCQR tool, however, does not include specific questions about these goals. Rather, its questions in this area determine whether the CM has facilitated access to employment services (Q46) and to CE services (Q54). The DBHDS staff we interviewed stated that "facilitated" would include the presence of goals in the record as

well as efforts to access resources and services. The word "facilitation" connotes helpfulness, not necessarily "accomplishing an outcome"; and DBHDS has not provided interpretive guidance that delineates what constitutes facilitation or a goal.

Later in this report I summarize the findings and conclusions from the employment qualitative study we undertook using the same 100 records that were part of the DBHDS SCQR monitoring initiative. This study did not find that meaningful discussions occurred at the rate that the CSBs report, nor did it find consistent follow-up by the Case Managers and ISP teams to educate individuals and families about employment and address barriers.

DBHDS continues to report that it has worked with the Case Management Coordinator and Performance Contracting staff to retrain all CSB case managers on these data elements. The E1AG and DBHDS have worked together to develop both written materials and a video for case managers to build their competencies to conduct employment discussions and develop meaningful employment goals for individuals. Materials and FAQs have also been completed for families. I summarized how well the training curriculum and related materials address the Compliance Indicators regarding employment training expectations for CMs in the seventeenth period report. During this nineteenth reporting period DBHDS addressed all expectations for CM employment training as detailed in the relevant Compliance Indicator. This is detailed in a later section of this report.

There is also considerable range in the individual levels of compliance across the forty CSBs. The range in the percentage of annual ISPs convened is from a low of 20% to a high of 90%. CSBs reports whether employment discussions occurred ranged from 44 to100%. Finally, the range of ISPs that include employment goals was reported to be from 6 to 46%. The CSB reports indicate that a high percentage of employment discussions occur as Virginia seeks to fully and effectively implement its Employment First policy. The CSBs self-report that they are not meeting the requirement of the SA to include an employment goal in 50% of the ISPs developed for adult waiver participants. This findings of our IDA 19th Period Study of 100 individuals served by all forty CSBs validated the CSB reports for setting employment goals.

There is a lack of evidence in the plans we reviewed in the IDA Study that meaningful discussions actually take place at many ISP annual meetings. Rather it is more typical that the question is asked if the individual or guardian wants employment considered. There is no evidence that the benefits of employment, the person's interests, skills and challenges are thoroughly discussed or that the plans then address these issues, or that the CM provides ongoing opportunity for the individual and family to learn more about employment or how providers or staff could help address barriers. It was not even apparent that CMs actually discuss the specific employment options offered by DARS and the HCBS waivers. DBHDS has still not demonstrated that it has the ability through its performance contract to require CSBs to take effective corrective actions that address and resolve repeated performance below acceptable standards.

We found that meaningful discussion occurred for 78% of the individuals. While this is an increase in the number and percentage of discussions from previous studies it is disheartening that it has not reached the CI expectation of 86% after so many years of implementation.

Community Engagement Discussion with Individuals- CSB CMs are also expected to have conversations with individuals on their caseloads about community engagement services. DBHDS reports that adults' case managers conducted a total of 11,786 annual ISP meetings or updates between July 1, 2020, and June 30,2021. However, there are 16,086 individuals on a HCBS waiver who have a CM and should have had an annual ISP meeting. This number, 16,086, is greater than the number 13,662 reported earlier in this report for the number of individuals who had ISP meetings in which the CM was expected to lead an employment discussion. This is because the employment discussion, unlike the discussion about CE, is required only for 18-64-year-old adults. The DBHDS report from the CSBs reflects data from ISP meeting for 73% of the total number of adults on one of the HCBS waivers. Of these 11,786 individuals, their case managers checked a box that indicated that a total of 10,949 individuals had discussed integrated, community-based employment during their annual ISP meetings. This indicates that 93% of the individuals who had an ISP meeting conducted discussed CE at some level. Our IDA Study this period found evidence of meaningful discussions occurring with only 59% of the 100 individuals in the sample. In addition, as reported above, the SCQR question related to CE was substantially inadequate to determine whether a meaningful discussion had occurred.

Four of the CSBs report that CMs had CE conversations with all of their waiver participants. The number of CSBs reporting these conversations with at least 86% of individuals was thirty-five. The Parties agreed to an indicator of compliance for community engagement discussions which set the expectation for 86% of all waiver participants to have these discussions.

The Parties also agreed to a Compliance Indicator that 86% of all individuals on the waiver who would have a community engagement goal. As reported by the CSBs this expectation has not been realized. The state average for setting CE goals remains at 38% in the nineteenth period. as reported in the seventeenth reporting period. There were not any CSBs who set goals for 86% of their waiver participants. One CSB reported setting CE goals for 81% of its waiver participants. It is important to look at the data specific to each of the forty CSBs. The following table, ***Table 7*** provides a breakdown of the percentage of individuals by CSB who were engaged in a discussion about CE and those who had a goal set for CE.

Table 7: Community Engagement Discussions and Goals June 2021		
% Of CSBs with Discussions or Goals Set	**Number of CSBs Holding CE Discussion**	**Number of CSBs Setting CE Goals**
100%	4	0
90-99%	27	0
80-89%	6	1
70-79%	2	2
60-69%	1	4
50-59%	0	7
40-49%	0	9
30-39%	0	7
20-29%	0	5
10-19%	0	4
0%	0	0

This review cannot determine whether the CSBs achieved the CI requirement that 86% of individuals had CE discussions. Whereas CSBs themselves reported falling substantially below the 50% requirement with only 38% of individuals having goals set for CE. Although the CSBs reported that 93% had discussions, ISPs were held for only 73% of the waiver population. Also, DBHDS did not determine that the CSB data could be used for compliance reporting, and it did not submit the SCQR findings for this reporting period to verify the CSB reporting. The SCQR process conducted by CSB Supervisors found that CE conversations occurred for 93% of the 400 individuals in the sample and DBHDS CQI staff agreed 92% of the time in their review of the 100 individuals in their sample.

In the seventeenth review period we found the process of the SCQR review process, valid. This was based on the information shared then that included the sample selection; training of the CQI reviewers; assuring inter-rater reliability; and the planned feedback sessions with the CSB CM Supervisors who completed the first level of the SCQR. However, we have reviewed the finalized review tool with its criteria and interpretive guidance and do not find the tool to be sufficient to assure valid findings of employment discussions or goals. We do not agree with the criteria they have established to determine that a meaningful discussion occurred. Also, the SCQR tool does not include specific questions to determine if goals have been established for individuals for employment and community engagement. This is discussed later in this report. Therefore, we cannot conclude that the SCQR methodology is valid.

Our study concluded that the Commonwealth has not achieved the requirements of ***CIs 14.02, 14.03, 14.05, or 14.06.*** While the CSB self-reported data indicate that the requirements of ***CI 14.02 and CI 14.05*** were met, our study found that a substantially smaller percentage of the required discussions occurred. In addition, the CSB data is required to be for all individuals with waiver services, but only represents approximately

75% of the cohorts for both employment and CE. Finally, DBHDS did not determine that the CSB data were reliable and valid and available for compliance reporting.

The Engagement of the SELN/E1AG - The VA SELN Advisory Group was established to assist DBHDS to develop its strategic employment plan; to set the targets for the number of individuals in the target population who will be employed; and to provide ongoing assistance to implement the plan and the Employment First Policy. The SELN Advisory Group was renamed the Employment First Advisory Group. Its members continue to be appointed for two-year terms. The E1AG has expanded to include members representing behavioral health and substance use. It includes self-advocates, family members, advocacy organization representatives, CSB staff, educators, employment providers, and representatives of the following state agencies: DBHDS, DMAS, DARS, and VDOE.

This Advisory Group has three sub-committees: training and education, best practices and data. I review the E1AG meeting minutes for meetings that occurred during the review year. These minutes were made available for this reporting period. I reviewed the E1AG minutes for the following meetings: 12/20; 2/21; 4/21; and 6/21. The minutes of the 8/21 meeting were not shared. The October meeting was held on 10/20 so the minutes were not yet available. The agendas for most of the meetings focused on reports from the state agency representatives. The Best Practices and Education Sub-Committees were often able to report on their activities. There were no reports from the Data Sub-Committee because DBHDS was unable to share data with the sub-committee throughout this reporting period. DBHDS was unable to share the December 2021 Semiannual Employment Draft Report with the E1AG but reported that the Semiannual Report for June 2021 was planned to be reviewed as part of the October agenda for the E1AG. All meetings reviewed were conducted via Zoom. Clearly the focus of many of the meetings was a discussion of the significant negative impact the COVID pandemic was having on employment for individuals with I/DD.

The two sub-committees, Best Practices and Education and Training continued to meet in this reporting period. A Guide to Supported Employment was developed by Best Practices and a very extensive framework for summarizing employment opportunities, resources and findings was developed by Education and Training. The next step is for the sub-committee to develop streamlined information descriptions that breakout this information for various stakeholder groups, so the framework is less voluminous and targeted information is shared for each stakeholder group The Best Practices sub-committee has also begun to address the needs of the mental health constituency that the E1AG now encompasses. Some of these initiatives may also benefit individuals with I/DD who have a co-occurring condition.

The recommendations of the RQC from Region 4 were presented to the E1AG on 2/17/21. The members of the RQC who attended identified barriers to employment that were occurring as a result of COVID and related safety restrictions.

I interviewed five members of the E1AG for this reporting period to gain perspective on the work of the advisory group and the progress the Commonwealth is making to meet the Settlement Agreement requirements for employment. It is apparent from the information

they provided that the E1AG and its sub-committees continue but have been much less active and met less frequently this year in part due to the COVID pandemic. The Data Committee did not receive any data reports from DBHDS in this reporting period so had no reason to meet.

1.***The operation of the SELN and the opportunity afforded its members to have input into the planning process -***most of the members I interviewed continue to report that the E1AG is an important group to sustain, and that it has a diverse and effective membership. Members are positive about the inclusion of new members who represent mental health and substance use needs in the Commonwealth. Members report that they have had less opportunity for meaningful input during this reporting period. There is a difference of opinion as to the value of having all meetings conducted using Zoom. All members interviewed understand this was necessary during the pandemic. While some felt it made the meetings more efficient, others are concerned that there has been far less engagement of the members in actually analyzing information and data or advising the state departments regarding the employment initiative. Members report that strategic planning for employment has stalled. They appreciate the structure of the sub-committees for best practices, training and data. However, there were fewer meetings of the subgroups in this reporting period, which was also reported during the past two previous reporting period. As stated earlier, the Data subcommittee never met due to the lack of data available to analyze. The members hoped that it would be helpful to have the Employment Services Coordinator to coordinate the work of the E1AG and the sub-committees. However, for unspecified reasons the members interviewed reported that this coordination has not occurred. Some members also expressed concerns that resources the sub-committees have developed have not necessarily been shared with stakeholders, and therefore question the usefulness and impact of their efforts.

Members continue to recommend that the E1AG's agendas and its work be driven more by the committee members with DBHDS responding to requests for data and providing progress reports on implementation of recommendations made by the E1AG.

2. ***Review of the Employment Targets***- Neither the December 2020 or June 2021 Semiannual Draft Reports on Employment had been shared with the Data Sub-Committee or the full E1AG as of the production of this report.

3. ***Review of CSB Targets-*** These could not be reviewed because of the lack of data presented to E1AG members.

4. Review of the RQC Recommendations- The Region 4 RQC recommendations were shared with the E1AG. The E1AG members agree with the general concerns but did not report that the E1AG had yet actively addressing these issues.

5. Interagency Initiatives- the members of the E1AG who I interviewed continue to be positive about the interagency cooperation between DBHDS and DARS. DARS allowed providers to assist individuals who had lost their jobs to apply for unemployment and also used emergency funding to help providers remain in business, DARS continues to focus attention on pre-employment planning with students ages 14 to17 and is devoting 15% of

vocational rehabilitation funding to this age group. DARS remains committed to increasing opportunities for Customized Employment, but has paused making referrals to providers. Provider capacity to provide this service has lessened, in part due staff turnover. Throughout this reporting period, the DARS LTESS program has remained open for those individuals in the most severe category of need. Both DARS and DBHDS provided reimbursement for some virtual services during the pandemic.

Conclusion and Recommendation: The DBHDS continues to meet the Settlement Agreement requirements to maintain the SELN/E1AG, and has set goals for the CSBs in their performance contracts. However, as reported and detailed earlier in this report DBHDS has not fully met the provisions of *III.C.7.b.* The CSBs have not consistently offered employment as the first and priority option or developed and discussed employment service goals annually, a target that the Commonwealth had projected would be achieved by June 2015. DBHDS has an Employment Services Coordinator. It is apparent from the review of the Employment Strategic Plan; the minutes of the E1AG meetings and interviews with E1AG members; and the overall lack of timely data production and analysis, that the strategic planning efforts to increase employment for individuals with I/DD have stagnated during the pandemic.

X. Regional Advisory Councils

III.C.7.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.

III.C.7.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.

RQC Regional Meetings

The minutes for the Regional Quality Councils (RQC) were shared for all five Councils. These meetings occurred for each RQC in FY21Q2, FY21Q3, and FY21Q4. Minutes for RQC meetings held during FY22 Q1 were not shared. Heather Norton or other DBHDS staff discussed employment targets with each RQC but did not share the data in the Semiannual Employment Draft Report of December 2020. There was no analysis done by the E1AG data committee. These analyses have been shared with the RQC's in previous reporting periods. During this reporting period the data from the Semiannual June 2021 report was not yet available for discussion.

During each Council meeting, the DBHDS staff provided updates on the trends in employment and the barriers created by the pandemic. Various Councils had more in-depth discussions and made recommendations. These discussions focused on: employment training for CMs and families; family hesitancy; the impact of employment on benefits; the need to support ESOs during program closures as a result of COVID. It was not evident that all of the recommendations of those RQCs that made suggestions were shared with the E1AG. However, as stated before the RQC from Region 4 attended the February 2021 meeting of the E1AG and shared its recommendations and perception of barriers to employment.

The RQCs' meeting minutes reflect that DBHDS consistently made presentations about employment. It does not appear that DBHDS has yet discussed the reductions it made in the employment targets for the waiver with any of the RQCs in this review period. These target reductions were also not discussed in the previous two review periods either.

The Councils continue to have members attend the meetings who represented individuals, families and employment providers.

The Commonwealth is responding to the requirement to involve the RQCs because the meetings were held, and employment issues were at least presented. Targets are expected to be reviewed on an annual basis and were not reviewed during this reporting period.

Conclusions and Recommendations: Although, DBHDS had previously achieved and maintained Sustained Compliance with provisions of III.C.7.c. and III.C.7.d, they did not fulfilled all the requirements during this reporting period. The employment target for sustaining employment for twelve months was not reviewed by the five RQCs in the reporting period. DBHDS did not appear to have shared employment data with the RQCs. The decreasing trends in employment were generally discussed by the RQCs, but DBHDS did not share related data. Some but not all of the RQCs had evidence of meaningful discussions. However, there is no evidence of the RQCs formally working with providers. I continue to recommend the role of the RQCs to review employment data be changed to semiannually to align with the availability of the Semiannual Employment Report and that each RQC make recommendations for consideration by the E1AG so all parts of the state have the opportunity for input that may lead to policy change. DBHDS has not fulfilled all of the requirements of III.C.7.c. and III.C.7.d. of the SA during this reporting period. A significant factor appears to have been the negative impact of the pandemic on DBHDS staff ability to complete well established protocols during this review period.

IX. A Review of the Compliance Indicators Agreed to by the Parties and Virginia's Progress Towards Achieving Compliance

Compliance Indicator CI 14.01 (a.-g.) The Commonwealth did not previously achieve the first compliance indicator for integrated day opportunities including employment, which includes the expectation of that all Case Managers (CM)take the online case management training and review the case management manual. For this review, the DBHDS provided a copy of the updated DBHDS Support Coordination/Case Management Employment

Training Module. DBHDS has included employment training for CMs in the CM orientation since 2015. ***CI 14.01*** of the SA for III.C.7.a requires all CMs to take the online training and review the CM Manual. The information must include seven components (***CI 14.01 a. – g.)*** which were previously reviewed and evaluated in the seventeenth review period. At that time, Virginia was found to have achieved the CM training expectations of ***CI 14.01 b, d, e, and h***, but had not fulfilled the expectations of ***CI 14.01 a, c, f and g*** which are described below. The current review determined that DBHDS has made sufficient revisions during this reporting period to its training to achieve the remaining indicator requirements. DBHDS issued the new materials to CSBs in June 2020 and were added to the online training October 1, 2020. Nine months later, Heather Norton, Assistant Commissioner sent an email on 6/30/21 to all CSB Developmental Services Directors and Executive Directors to reinforce the DBHDS expectation and to ensure that the CSBs meet the SA requirement that the new training materials be shared with all existing and newly hired CMs in advance of its availability online. She received confirmation that this was done by all the Directors of the 40 CSBs.

14.01 a. The Employment First Policy with an emphasis on the long-term benefits of employment to people and their families and practical knowledge about the relationship of employment to continued Medicaid benefits.

FACTS: DBHDS updated its training curriculum to ensure CMs have a better grasp about long-term benefits and their relationship to employment of individuals with I/DD. The information in the DBHDS CM training and manual is sufficient to meet the requirements of ***CI 14.01a.*** Previously the CMs training lacked practical knowledge of the impact of employment on Medicaid's financial and health benefits.

CONCLUSION: ***The Commonwealth has fulfilled the requirements of CI 14.01 a.***

14.01 c. The importance of discussing employment with all individuals, including those with intense medical or behavioral needs and their families.

FACTS: Virginia supports its Employment First Policy several years ago. The Commonwealth's policy states that "employment is the first and preferred outcome in the provision of publicly funded services for *all working age citizens, regardless of disability."* This statement is included and discussed in the CM Employment Training. A section of the training titled, "Myths, Misconceptions, or Realities addresses the needs of individuals with medical or behavioral complexities through the use of vignettes of individuals who have these issues and are employed. The CM training encourages work for these individuals and cites research of the benefits of working on behavioral, mental and physical health.

Virginia supports employment for all individuals regardless of the level, severity, and type of disability. The training reinforces that employment should be discussed with all individuals and their families. The videos of individual employment situations are useful to assist meaningful discussion. Previously, the training in 2020 did not include sufficient information or training about promoting work opportunities for individuals with intense medical or behavioral needs.

ANALYSIS: The revised training does equip the CM to address questions or concerns families, or individuals may have regarding complex disabilities. It now includes information about behavioral or medical supports that may be available to individuals with these needs. It references how a Behavior Support Professional or the development of a behavioral plan may prepare an individual with behavioral complexity to eventually work. It also makes CMs aware of other Therapeutic Consultation services including occupational and physical therapies. The training provides examples of appropriate conversations to have with individuals with intense medical or behavioral needs to encourage them to consider employment.

CONCLUSION: ***The Commonwealth has fulfilled the requirements of CI 14.01 c.***

14.01 f. Developing goals for individuals utilizing Community Engagement Services that can lead to employment (e.g., volunteer experiences, adult learning).

FACTS: The value of community engagement and coaching services are included in the training section of the CM manual regarding planning for 14-17-year-old students. A section on Link to Resources includes community colleges and other post-secondary educational opportunities to enhance skills for learning opportunities and adult learning classes. Previously, there was no information or training about the value or availability of community engagement services to lead to employment in 2020.

ANALYSIS: The Employment training for CMs now meet this CI. The training now includes relevant information about community engagement for all individuals with I/DD. The training educates CMs about using CE services effectively for skill building, making connections, and helping individuals form social relationships.

CONCLUSION: ***The Commonwealth has fulfilled the requirements of CI 14.01 f.***

14.01 g. Making a determination during their monitoring activities as to whether the person is receiving support as described in the person's plan and that the experience is consistent with the standards of the service.

FACTS: The Employment training includes a module on monitoring progress that emphasizes the responsibility of the CM to monitor the services in the plan for either preparing a person for work and addressing barriers to employment or making sure if a person is employed that it is in a job they want and if they would prefer other options. Previously the training did not reference the standards of the service the individual is using or how to ensure those standards are being met, nor did it provide instruction as to how this monitoring may occur during visits, how it should be documented, or what is the expectation for the CM's follow up if the support is not being received or program standards are not being met.

ANALYSIS: The previously identified issues have all been suitably addressed in the revised training.

CONCLUSION: ***The Commonwealth has fulfilled the requirements of CI 14.01 f.***

The Commonwealth is to ensure all CMs take the online training modules and review the CM manual. Previously the related data were maintained by Virginia Commonwealth University (VCU). VCU also requires each CM take a test after completing the online training. The CM must pass the test with a score of at least 80% for the training to be confirmed as completed. DBHDS will maintain the data in its own online training database in FY22.

DBHDS indicates it reviews the data VCU has for each CSB compared to the number of CM FTEs in each CSB to determine if all CMs were trained in 2020. The department does not have data to confirm names but reports it has confidence that al CMs have been trained because the numbers reported by VCU are greater than the number of FTEs which DBHDS reports accounts for turnover of case managers. However, no actual data was produced for this review regarding the number of CMs trained, and DBHDS does not have an entirely accurate methodology to verify that every CM has taken the online training. DBHDS did have confirmation that the revised materials were shared by every CSB with its CMs in June 2021. DBHDS will be maintain all CM training data in the future rather than relying on VCU.

Overall Conclusion: In conclusion Virginia now fully meets the requirements of the set of requirements ***CI 14.01 a. – g.*** regarding employment and community engagement training for its CMs. Therefore, the Commonwealth has achieved ***CI 14.01.***

The second CI regarding employment expectations of the SA, ***CI 14.02*** focuses on the discussions of employment and community engagement; the goal setting for employment and CE services; and the initiation of employment services. Below is a summary of the Commonwealth's status supplying verified data and meeting the CI measures. Many of the reasons for the findings of compliance have been detailed in earlier sections of the report.

CI 14.02 At least 86% of individuals (age 18-64) who are receiving waiver services will have a discussion regarding employment as part of the ISP planning process.

FACTS: DBHDS uses the self-reporting from the CSBs to report on this CI. DBHDS has not determined that these data are reliable and valid and are available for compliance reporting.

ANALYSIS: In addition to DBHDS not yet validating the data reported by the CSBs, the independent IDA Study of 100 records during the19th period found that employment discussions occurred in only 78% of the records reviewed. Whereas, the CSBs self-reported that discussions were held with 97% of the individuals who had ISP meetings between June 2020 and June 2021 The DBHDS cannot produce reliable, valid, verified data regarding this

CI. The DBHDS SCQR process and tool were designed to provide this data but as has been referenced earlier in this report, DBHDS is not using the findings of the SCQR as it relates to employment and CE discussions and goals and CIs. The CSB methodology for collecting this data has not been verified.

CONCLUSION: ***The Commonwealth has not met the requirements of CI 14.02.***

CI 14.03 At least 50% of ISPs of individuals (age 18-64) who are receiving waiver services include goals related to employment. The DBHDS cannot produce reliable, valid, verified data regarding this CI.

FACTS: The CSBs report that employment goals were set for 28% of the individuals who had ISP meetings between June 2020 and June 2021.

ANALYSIS: The percentage is far below the expectation of 50% and the CSB methodology for collecting this data has not been verified.

Conclusion: ***The Commonwealth has not met the requirements of CI 14.03.***

CI 14.04 At least 86% of individuals who are receiving waiver services and have employment services authorized in their ISPs will have a provider and begin services within 60 days.

FACTS: DBHDS completed a Monitoring Questionnaire for data verification in the seventeenth period. It was reported to be based on reliable information from the WaMS system and from ESOs. However, DBHDS was unable to produce any data to determine compliance this reporting period.

ANALYSIS: DBHDS did not produce any data to analyze related to this CI.

CONCLUSON***: The Commonwealth has not met the requirements of CI 14.04.***

CI 14.05 At least 86% of individuals who are receiving waiver services will have a discussion regarding the opportunity to be involved in their community through community engagement services provided in integrated settings as part of their ISP process.

FACTS: DBHDS uses the self-reporting from the CSBs to report on this CI. DBHDS has not determined that these data are reliable and valid and are available for compliance reporting.

ANALYSIS: The DBHDS cannot produce reliable, valid, verified data regarding this CI. The SCQR was designed to provide this data but has been referenced earlier in this report DBHDS is not using the findings of the SCQR as it relates to employment and CE discussions and goals and CIs. The CSBs report that discussions are held with 93% of the individuals

who had ISP meetings between June 2020 and June 2021 but the CSB methodology for collecting this data has not been verified. The findings of the IDA Study does not confirm this data. We found discussions occurred in only 59% of the records reviewed.

CONCLUSION: ***The Commonwealth has not met the requirements of CI 14.05.***

CI 14.06 At least 86% of individuals who are receiving waiver services will have goals for involvement in their community developed in their annual ISP.

FACTS: The CSBs report that CE goals were set for 38% of the individuals who had ISP meetings between June 2020 and June 2021. Also, the CSB methodology for collecting this data has not been verified and DBHDS has not determined that the CSB data are reliable and valid and are available for compliance reporting.

ANALYSIS: The percentage is far below the expectation of 86% and the CSB methodology for collecting this data has not been verified.

CONCLUSION: ***The Commonwealth has not met the requirements of CI 14.06.***

CI 14.07 At least 86% of individuals ages 14-17 who are receiving waiver services will have a discussion about their interest in employment and what they are working on while at home and in school toward obtaining employment upon graduation, and how the waiver services can support their readiness for work, included in their ISP.

FACTS: DBHDS provided data regarding the employment discussions that were held with adolescents ages 14-17. These reports began to be produced in May 2021, so the data is only for five months of the reporting period. CMs are expected to discuss the three topics stated above in the CI. DBHDS reports on the following categories: employment discussion; Topic 1-what is being worked on in home and at school; and Topic 2-alternate funding.

The data is summarized in ***Table 8*** below:

Table 8: Employment Discussions Ages 14-17

Month	All ISPs	ISPs 14-17	Discussion	Topic 1	Topic 2	Both Topics
May /June	Not reported	30	26	15	11	11
July	1093	21	20	10	11	9
August	1099	36	31	12	18	11
September	1001	32	31	13	15	10
TOTAL	**3193**	**119**	**108**	**50**	**55**	**41 (34%)**

ANALYSIS: The data is for less than half of the reporting period. The percentage of individuals who are reported to have had a discussion in only 34%. Also, DBHDS has not submitted its process for collecting and verifying this data. It did submit the MQ that includes this CI but the method for collecting this data was not used until FY22 so does not address data collected for this reporting period. This FY22 data will be reviewed in the next reporting period after DBHDS has determined that the CSB data are reliable and valid and are available for compliance reporting. The DBHDS determination will also verify the methodology for collecting the data. DBHDS did not provide an interpretation of the topics in the above table so I cannot confirm that employment discussions include queries about interest and that the discussion of alternative funding includes a discussion of how waiver services can support one's readiness to work.

CONCLUSION: ***The Commonwealth has not met the requirements of CI 14.07.***

CI 14.08 New Waiver Targets established by the Employment First Advisory Group. The data target for FY20 is 936 individuals in ISE: 550 individuals in GSE for a total of 1486 in supported employment. Compliance with the Settlement Agreement is attained when the Commonwealth is within 10% of the targets.

CI 14.09 The Commonwealth has established an overall target of employment of 25% of the combined total of adults ages 18-64 on the DD waivers and waitlist.

CI 14.10 DBHDS service authorization data continues to demonstrate an increase of 3.5% annually of the DD Waiver population being served in the most integrated settings as defined in the Integrated Employment and Day Services Report (an increase of about 500 individuals each year as counted by unduplicated number recipients).

FACTS: The data for the targets in these three CIs is reported in the Semiannual Employment Report that has been issued by the DBHDS for the past eleven reporting periods. Integrated Day Services include CC, CE, ISE, GSE and WA. DBHDS completed a Monitoring Questionnaire for data verification. The changes in the number of individuals authorized is displayed in ***Table 5*** in this report. There were significant decreases in service authorizations.

ANALYSIS: The DBHDS reports information from the WaMS system and from ESOs. As has been noted earlier in this report the employment targets were not met as of June 2021.

CONCLUSION: ***The Commonwealth has not met the requirements of CI 14.08, 14.09 and 14.10.***

XI. Summary

DBHDS previous trend of gains in supported employment and in its efforts to implement community engagement through 2019 have continued to be stymied by the COVID pandemic during this reporting period. Its progress towards achieving its multi-year employment targets continues a downward trend. It will require a significant increase in these employment opportunities in FY22 to meet the Compliance Indicators for employment targets and the target for the percentage increase for individuals participating in all integrated day activities. The percentage of meeting its overall target for employment dropped from 19% to 18%, between June 2020 and June 2021, versus the expectation that 25% of all individuals on the waivers or the waiting lists will be employed. The number of individuals employed through HCBS waiver services continued to decline during the COVID pandemic. While it is not unexpected that COVID has continued to have a negative impact, it is concerning that the Commonwealth's IDA initiative has been stalled. One hopes that many of these individuals who lost jobs are being rehired and employment will improve over the next several months.

The Commonwealth cannot confirm that it has achieved its targets set for the CSBs for employment and CE discussions and for employment and CE goal setting in the ISPs of waiver participants.

The Stakeholders who are part of the E1AG remain interested and positive about the Commonwealth's progress and achievements. DBHDS has hired a new Employment Services Coordinator who will devote time to assisting the E1AG to achieve its goals to undertake and report trend analyses; address employment barriers; and make continued recommendations to increase employment options for individuals with I/DD, but her time needs to be more focused on assisting the E1AG.

ATTACHMENT 1 - Quality Review and Verification of SCQR

Integrated Day Activities Including Supported Employment Study
19th Review Period

By Kathryn du Pree MPS and Joseph Marafito MS

Introduction and Study Methodology

At the request of the Independent Reviewer, a record review of employment and community engagement (CE) was undertaken in this review period to provide added information to the data reports provided by DBHDS which summarizes statewide data for various aspects of employment and community engagement for individuals with I/DD. The purpose of the review was to determine if there were meaningful discussions about employment interests and options and about increasing opportunities for engaging in community-based activities on a regular basis; and whether an individual employment or employment readiness goal and/or community engagement goal were established for the individuals. DBHDS had its CQI staff randomly select 100 records for its quality review and verification of SCQR reviews of 400 records that were reviewed by CSB supervisors. We reviewed the same 100 records that were reviewed by the DBHDS CQI staff.

The study included a review of the written plans and any other documentation related to employment and Community Engagement (CE) discussions during the face-to-face ISP meetings and interactions with team members during Calendar Year 2020. DBHDS shared ISPs; Provider Part V sections detailing service implementation plans; the CM quarterly reviews of each ISP; and the CM progress notes.

One hundred adults were selected as the sample for this DBHDS CQI quality review and for this study of employment and CE, which are the two primary waiver-funded services in Virginia that comprise integrated day activities. The selected sample included 100 individuals served by case managers from all forty CSBs whose ISP annual meetings were convened in the year prior to January 2021. Progress notes were shared documenting the interactions of the CM with the individual, family and team members between January 2020 and December 2020. Each CSB had 2-4 individuals in the sample that CQI staff reviewed and that we subsequently reviewed. The selected individuals were affiliated with the following regions:

- Region 1- 23
- Region 2-13
- Region 3-24
- Region 4-19
- Region 5-21

The independent expert reviewers studied all the documents to answer the following questions:

- Did the individual's planning team meaningfully discuss employment with the individual at the annual ISP meeting?
- Did the team identify and address any barriers to employment?
- Did the team, with the participation of the individual and authorized representative (AR), set an employment goal or employment readiness goal for the individual?
- If the individual or AR was not interested in employment at the time of the ISP meeting did the team develop strategies to educate the individual and family about the benefits of employment?
- Did the individual's planning team meaningfully discuss community engagement with the individual at the annual ISP meeting?
- Did the team identify and address any barriers to community engagement?
- Did the team, with the participation of the individual and AR, set a community engagement goal for the individual?
- If the individual or AR was not interested in community engagement at the time of the ISP meeting did the team develop strategies to educate the individual and family about the benefits of community engagement?

The SCQR process includes a review of ten compliance indicators associated with case management responsibilities and what is labeled "all other questions". In this section there are seven questions that address employment and community engagement.
Q42: Is there evidence in the record that the SC/CM discussed options for employment?
Q43: Is there evidence elsewhere in the record that the SC/CM discussed options for employment?
Q46: Is there evidence in the record that the SC/CM facilitated access for employment? (Percentage yes is for yes or not applicable)

Q47: Is there evidence elsewhere in the record that the SC/CM facilitated access to employment? Yes, or not applicable
Q50: Is there evidence in the record that the SC/CM discussed options for integrated community involvement/Community Engagement/Community Coaching?
Q51: Is there evidence elsewhere in the record that the SC/CM discussed options for integrated community involvement/Community Engagement/Community Coaching?
Q54: Is there evidence in the record that the SC/CM facilitated access to integrated community involvement/Community Engagement/Community Coaching?

We did not have these questions or the results of the SCQR completed by the CQI staff until well after we completed our record review nor were we able to interview the CQI staff until our review and analysis was complete. When we reviewed the records, we indicated the CM had met the requirement to have a discussion about either employment or CE/CC if there was any evidence of those discussions in ither the ISP or the progress notes.

We also reviewed the records to determine whether interest in employment exists because DBHDS expects goals to be developed if there is an interest. If there is no interest in either employment or CE/CC, DBHDS expects that the CM, and the team will educate the family and individual about these service options to help them develop these interests and eventually make an informed decision about these services. These expectations are addressed in the CM training developed by DBHDS. We provide an analysis of whether there are educational efforts underway and whether barriers are identified and addressed to provide information to DBHDS for further training, technical assistance and monitoring of CSB CM services in the area of promoting integrated day activities. The SCQR process does not include questions about interest in employment or CE.

In order to make these determinations we considered the following issues:

1. Is there documentation of the employment and community engagement discussions?
2. Were the individual's and/or AR's opinions, desires, and concerns included in the discussions?

3. Did the discussions include determining what the individual's interests and skills are?
4. Did the discussions include any challenges or barriers to employment or community engagement that the individual is experiencing?
5. Did the discussions include an explanation of the employment and CE options that are available to the individual?
6. Did the team review the impact of employment on the individual's benefits if the individual was interested in working?
7. If the individual is interested in working did the team recommend related assessments if not already done?
8. Was an employment or employment readiness goal created?
9. Does the goal reflect the employment and CE discussions (strengths, preferences, needs and barriers)?
10. Is the goal/outcome measurable?
11. Does the plan include goals, objectives, and activities to promote the individual's participation in integrated day activities?
12. Do these integrated day activities reflect the strengths, preferences and needs of the individual?
13. Do these integrated day activities promote active participation for the individual in the community?

These are the criteria for review that we have used since we began reviewing individual records for the purpose of determining compliance with the Settlement Agreement as well as with the specific Compliance Indicators once they were agreed to by the Parties. These criteria reflect the expectations of DBHDS as articulated in its Employment and Community Engagement Training for CMs.

Medical and Behavioral Concerns

Pursuant to the Commonwealth's Employment First policy and its Employment Plan, DBHDS is committed to providing supports in both employment and CE for individuals who may have medical or behavioral concerns that must be addressed for the individuals to successfully work or engage in the community interacting with typical peers in a meaningful way. Of the 100 individuals in the sample for this study, eleven have medical conditions that the team would need to address, and thirty-seven have behavioral concerns that may be barriers to employment or community inclusion. Only seven of the eleven individuals with medical concerns have

such a significant health concern that the health issue may preclude work. These concerns include individuals who have quadriplegia; are frequently suctioned and use a ventilator; or whose medical fragility preclude them from being out of their home settings because of fear of infection or lack stamina to engage in activities. We made these determinations based on our review of the ISP sections that summarize risk assessment data; the need for and presence of a behavior support plan for each individual in the sample; the ongoing use of crisis services; and updates in the progress notes about medical conditions or behavior status.

DBHDS expects teams will work to address individuals' medical and behavioral concerns if there are barriers to employment and community engagement. There was evidence in the records reviewed that teams were addressing the behavior issues for twenty-two (81%) of the twenty-seven individuals with behavioral needs. This is a significant increase over 2020 when this percentage was 57%. The majority of these individuals had a Behavior Support Professional (BSP) and/or a behavioral plan. There were eleven individuals in the IDA Study who had medical conditions that needed to be addressed. Of these eleven individuals there was evidence in the records reviewed that teams were addressing these medical concerns as they might impact employment and CE for all of them, compared to 61% of individuals with medical concerns who were included in the 2020 IDA Study.

Findings

ISP document review - DBHDS provided the ISPs for the individuals and included the Part V sections completed by the CMs and providers. The section of the ISP that addresses employment and CE is comprised of check off boxes for each service related to the discussion by the team. The team is supposed to discuss the individual's interest; whether the person is deciding to retire; a listing of barriers; and whether there is a plan to further educate the individual and family about employment and CE. Not all CSBs use the same ISP format. There is an area in the ISP that some but not all CSBs use that provides an opportunity for the CM to enter information that would document what comprised these discussions; or what was being planned to address the barriers. There is a section for the CM to document how the CM and team planned to provide further education and information about employment or

CE for individuals who were not interested at the time of the meeting. However, this was rarely completed e We confirmed that an employment or CE discussion occurred if there was any documentation in the ISP, Quarterly Reviews, or progress notes that explained or summarized an actual discussion. As we have stated in previous study reports, the self-reported check boxes, or single statements that "an employment discussion was held" do not reliably verify that a meaningful discussion has in fact occurred. There is a section of the ISP document titled "Important To" (the individual). The instructions indicate seven life areas for review and discussion. Few of the ISPs we reviewed contained complete information in this area about employment and community engagement. In some records an interest in one of these areas was discussed in this section and yet there was not any specific follow up in the goals for the individual. If there was evidence of including what was important to the person in this section, we determined their interest was being determined.

The Part V sections of the ISPs that were shared were the Part Vs completed by the CM, and the CE, SE or Group Day provider, as well as the residential provider. Overall, this study found that the goal statements in the Section V were weak, as they were very general and for the most part reflective of basic rights and life expectations. For example, few of the outcomes/goals include measurable objectivities that would allow the CM to be aware of real progress or the need to possibly modify an ISP because of a lack of progress. Also, if goals that are not measurable, their achievement cannot be objectively determined and, therefore inherently contribute to unreliable data that are provided by CMs and verified by their supervisors. This same finding was noted in our last IDA Study that was conducted in the seventeenth reporting period. There are some exceptions to goal statements not being measurable. CSBs should use model ISPs and Part V sections as part of their follow up training for CMs to complement the training that is offered by DBHDS.

Employment Discussions and Goal Setting

Table 1 below summarizes by CSB the findings for the CMs fulfilling the Commonwealth's employment policy and case management expectations. This Table includes "Yes" answers when the documentation reviewed provided evidence of discussing employment; determining the individual's interest; identifying and addressing barriers to employment; setting employment goals and planning to further educate individuals who are not currently interested

in employment. The Table compiles and displays information for each Region's sample and an aggregate total of compliance for each element for each Region and for the entire sample.

TABLE 1: EMPLOYMENT SUMMARY							
	Employ. Discussion	Interest	Plan to Educate	Plan Implement.	Goals Set	Identified Barriers	Addressed Barriers
REGION 1 (WESTERN)							
WR1	YES	NO	NO	NO	N/A	YES	NO
WR2	YES	YES	N/A	N/A	YES	YES	YES
WR3**	YES	NO	N/A	N/A	N/A	NONE	N/A
WR4	YES	NO	NO	NO	N/A	YES	YES
WR5**	YES	NO	N/A	N/A	N/A	YES	YES
WR6**	YES	NO	N/A	N/A	N/A	YES	YES
WR7	NO	NO	NO	NO	N/A	YES	NO
WR8	YES	YES	N/A	N/A	NO	YES	YES
WR9	YES	YES	N/A	N/A	YES	YES	YES
WR10**	YES	NO	N/A	N/A	N/A	YES	YES
WR11***	YES	NO	N/A	N/A	N/A	YES	YES
WR12	YES	YES	N/A	N/A	YES	YES	YES
WR13**	YES	NO	N/A	N/A	N/A	YES	YES
WR14	YES	NO	NO	NO	N/A	YES	NO
WR15	YES	NO	NO	NO	N/A	YES	NO
WR16	YES	YES	N/A	N/A	YES	YES	YES
WR17	YES	YES	N/A	N/A	YES	YES	YES
WR18	YES	YES	N/A	N/A	YES	YES	YES
WR19***	NO	NO	N/A	N/A	N/A	YES	YES
WR20***	YES	NO	N/A	N/A	N/A	YES	YES
WR21	YES	NO	YES	YES	N/A	YES	YES
WR22	YES	NO	NO	NO	N/A	YES	YES
WR23	YES	NO	NO	NO	N/A	NONE	N/A
REGION COMPLIANCE %	91%	30%	12%	12%	86%	100%	81%
ACTUAL NUMBER	21 of 23	7 of 23	1 of 8	1 of 8	6 of 7	23 of 23	17 of 21

	Employ. Discussion	Interest	Plan to Educate	Plan Implement.	Goals Set	Identified Barriers	Addressed Barriers
REGION 2 (NORTHERN)							
NR1	**YES**	**NO**	**YES**	**YES**	**N/A**	**NONE**	**N/A**
NR2***	**YES**	**NO**	**N/A**	**N/A**	**N/A**	**YES**	**YES**
NR3	**YES**	**NO**	**NO**	**NO**	**N/A**	**YES**	**YES**
NR4	**YES**	**YES**	**N/A**	**N/A**	**YES**	**NONE**	**N/A**
NR5	**YES**	**YES**	**N/A**	**N/A**	**NO**	**YES**	**YES**
NR6	**YES**	**NO**	**NO**	**NO**	**N/A**	**YES**	**YES**
NR7**	**YES**	**NO**	**N/A**	**N/A**	**N/A**	**YES**	**YES**
NR8	**YES**	**YES**	**N/A**	**N/A**	**YES**	**NONE**	**N/A**
NR9	**YES**	**NO**	**YES**	**YES**	**N/A**	**YES**	**YES**
NR10	**YES**	**YES**	**YES**	**YES**	**YES**	**YES**	**YES**
NR11	**YES**	**YES**	**N/A**	**N/A**	**YES**	**NONE**	**N/A**
NR12	**YES**	**YES**	**N/A**	**N/A**	**YES**	**NONE**	**N/A**
NR13	**YES**	**YES**	**N/A**	**N/A**	**YES**	**NONE**	**N/A**
REGION COMPLIANCE %	**100%**	**54%**	**60%**	**60%**	**86%**	**100%**	**100%**
ACTUAL NUMBER	**13 of 13**	**7 of 13**	**3 of 5**	**3 of 5**	**6 of 7**	**13 of 13**	**7 of 7**

	Employ. Discussion	Interest	Plan to Educate	Plan Implement.	Goals Set	Identified Barriers	Addressed Barriers
REGION 3 (SOUTHERN)							
SW1	**YES**	**NO**	**YES**	**YES**	**N/A**	**NONE**	**N/A**
SW2**	**YES**	**NO**	**N/A**	**N/A**	**N/A**	**NONE**	**N/A**
SW3	**YES**	**YES**	**N/A**	**N/A**	**YES**	**NONE**	**N/A**
SW4**	**YES**	**NO**	**N/A**	**N/A**	**N/A**	**YES**	**YES**
SW5	**NO**	**NO**	**NO**	**NO**	**N/A**	**NO**	**NO**
SW6	**NO**	**NO**	**NO**	**NO**	**N/A**	**NONE**	**N/A**
SW7	**YES**	**NO**	**NO**	**NO**	**N/A**	**NONE**	**N/A**
SW8	**YES**	**YES**	**N/A**	**N/A**	**YES**	**YES**	**YES**
SW9	**YES**	**NO**	**NO**	**NO**	**N/A**	**YES**	**YES**
SW10	**NO**	**NO**	**NO**	**NO**	**N/A**	**YES**	**NO**
SW11**	**YES**	**NO**	**N/A**	**N/A**	**N/A**	**YES**	**YES**
SW12*	**YES**	**NO**	**NO**	**NO**	**N/A**	**YES**	**NO**
SW13	**YES**	**YES**	**N/A**	**N/A**	**YES**	**NONE**	**N/A**
SW14	**YES**	**YES**	**N/A**	**N/A**	**NO**	**NONE**	**N/A**
SW15**	**YES**	**NO**	**N/A**	**N/A**	**N/A**	**YES**	**YES**
SW16**	**YES**	**NO**	**N/A**	**N/A**	**N/A**	**YES**	**YES**
SW17	**YES**	**NO**	**NO**	**NO**	**N/A**	**NONE**	**N/A**
SW18	**YES**	**YES**	**YES**	**YES**	**YES**	**YES**	**YES**
SW19	**YES**	**YES**	**N/A**	**N/A**	**YES**	**NONE**	**N/A**
SW20	**YES**	**NO**	**NO**	**NO**	**N/A**	**YES**	**NO**
SW21	**YES**	**NO**	**NO**	**NO**	**N/A**	**YES**	**YES**
SW22	**NO**	**NO**	**NO**	**NO**	**N/A**	**YES**	**YES**
SW23	**NO**	**NO**	**NO**	**NO**	**N/A**	**YES**	**YES**
SW24	**YES**	**NO**	**N/A**	**N/A**	**N/A**	**NONE**	**N/A**
REGION COMPLIANCE %	**79%**	**25%**	**15%**	**15%**	**83%**	**96%**	**71%**
ACTUAL NUMBER	**19 of 24**	**6 of 24**	**2 of 13**	**2 of 13**	**5 of 6**	**23 of 24**	**10 of 14**

	Employ. Discussion	Interest	Plan to Educate	Plan Implement.	Goals Set	Identified Barriers	Addressed Barriers
REGION 4 (CENTRAL)							
CR1	**NO**	**NO**	**NO**	**NO**	**N/A**	**YES**	**NO**
CR2*	**YES**	**NO**	**NO**	**NO**	**N/A**	**YES**	**YES**
CR3**	**YES**	**NO**	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**
CR4	**YES**	**YES**	**N/A**	**N/A**	**YES**	**NONE**	**N/A**
CR5	**YES**	**NO**	**NO**	**NO**	**N/A**	**NONE**	**N/A**
CR6**	**YES**	**NO**	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**
CR7	**YES**	**YES**	**N/A**	**N/A**	**YES**	**NONE**	**N/A**
CR8	**YES**	**YES**	**N/A**	**N/A**	**YES**	**YES**	**YES**
CR9	**YES**	**YES**	**N/A**	**N/A**	**YES**	**YES**	**NO**
CR10	**YES**	**YES**	**N/A**	**N/A**	**YES**	**NONE**	**N/A**
CR11**	**YES**	**NO**	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**
CR12	**NO**	**NO**	**NO**	**NO**	**N/A**	**NONE**	**N/A**
CR13	**NO**	**NO**	**NO**	**NO**	**N/A**	**NONE**	**N/A**
CR14	**YES**	**YES**	**N/A**	**N/A**	**YES**	**YES**	**YES**
CR15	**YES**	**YES**	**N/A**	**N/A**	**NO**	**YES**	**YES**
CR16	**YES**	**YES**	**N/A**	**N/A**	**NO**	**YES**	**NO**
CR17	**NO**	**NO**	**NO**	**NO**	**N/A**	**NONE**	**N/A**
CR18	**NO**	**NO**	**NO**	**NO**	**N/A**	**NO**	**NO**
CR19	**YES**	**YES**	**N/A**	**N/A**	**YES**	**NONE**	**N/A**
REGION COMPLIANCE %	**74%**	**47%**	**0%**	**0%**	**78%**	**94%**	**50%**
ACTUAL NUMBER	**14 of 19**	**9 of 19**	**0 of 7**	**0 of 7**	**7 of 9**	**15 of 16**	**4 of 8**

	Employ. Discussion	Interest	Plan to Educate	Plan Implement.	Goals Set	Identified Barriers	Addressed Barriers
REGION 5 (EASTERN)							
ER1	NO	NO	NO	NO	N/A	NONE	N/A
ER2	NO	NO	NO	NO	N/A	NONE	N/A
ER3***	YES	NO	N/A	N/A	N/A	YES	YES
ER4***	YES	NO	N/A	N/A	N/A	YES	YES
ER5	NO	YES	N/A	N/A	NO	NONE	N/A
ER6	NO	NO	NO	NO	N/A	YES	YES
ER7****	YES	YES	N/A	N/A	NO	YES	YES
ER8	YES	YES	N/A	N/A	YES	YES	YES
ER9	NO	YES	N/A	N/A	YES	NONE	N/A
ER10**	YES	NO	N/A	N/A	N/A	N/A	N/A
ER11	YES	YES	N/A	N/A	YES	NONE	N/A
ER12***	YES	NO	N/A	N/A	N/A	YES	YES
ER13	NO	YES	N/A	N/A	YES	YES	NO
ER14	NO	YES	N/A	N/A	NO	YES	NO
ER15**	YES	NO	N/A	N/A	N/A	N/A	N/A
ER16	NO	YES	N/A	N/A	NO	YES	NO
ER17	YES	YES	N/A	N/A	NO	YES	YES
ER18	NO	YES	N/A	N/A	NO	YES	YES
ER19**	YES	NO	N/A	N/A	N/A	N/A	N/A
ER20	NO	NO	NO	NO	N/A	NONE	N/A
ER21**	YES	NO	N/A	N/A	N/A	N/A	N/A
REGION COMPLIANCE %	52%	48%	0%	0%	40%	100%	73%
ACTUAL NUMBER	11 of 21	10 of 21	0 of 4	0 of 4	4 of 10	17 of 17	8 of 11
TOTAL % NUMBER	78%	39%	15%	15%	72%	98%	75%
TOTAL NUMBER	78 of 100	39 of 100	6 of 39	6 of 39	28 of 39	91 of 93	46 of 61

KEY:

* AR does not want employment

** Retired

*** Unable to work b/c significant medial concerns

**** No barriers checked but has behaviors to address and team is addressing them

Employment Discussion- DBHDS expects that CSB CMs will have employment discussions with 100% of the individuals on their caseloads (between the ages of 18-64) at the ISP annual meeting. The Parties have agreed that compliance with this indicator will be reached when these discussions occur with 86% of adults between the ages of 18-64 who are on a HCBS waiver. DBHDS reported in its Semiannual Employment Report that these discussions were held for 97% of all individuals during FY21 for whom an ISP was held. During the twelve-month period, ISPs were held for only 75% of the waiver participants.

In contrast with the number and percentage of individuals with employment discussion as self-reported by CMs, our study found that sufficient discussions were held for only 78% of the selected sample overall, compared to 72% and 73% in the independent IDA Studies completed by these reviewers in 2020 and 2019. The percentage of individuals with whom discussions were held across the five Regions in the study ranged from 52 in Region 5 to 100% in Region 1. The SCQR for the same time period reports the following results: the Supervisors determined there was evidence of a discussion in 95% of the records and the CQI agreed with these findings 88% of the time. However, the DBHDS's interpretive guidance for the SCQR question to determine whether a meaningful discussion occurred is insufficient to verify if a meaningful discussion occurred. DBHDS guidance includes a list of criteria, which is similar to what we consider evidence of a discussion, for the CM supervisor and CQI reviewers, but the DBHDS guidance states that the reviewers needs to find evidence of only one of these criteria being present to determine that a meaningful discussion occurred. It is our considered opinion that this guidance (i.e., evidence of meeting only one criterion) does not provide adequate validation of a true discussion occurring. This is explained and discussed in greater detail in the 2021 Review of the IDA Requirements of the Settlement Agreement Report for the 19th Period.

Almost all the ISPs reviewed included a checkmark that an employment conversation occurred. In making our determinations we expected to see evidence that a meaningful discussion occurred including a discussion of the person's interests and history of employment; their skills related to employment; the employment services available through DARs and HCBS waivers; and the barriers that they or their family felt existed to successful employment. We confirmed an employment discussion occurred if there was any documentation in the ISP, Quarterly Reviews or progress notes that

explained or summarized an actual discussion that included these points. Again, it appears that self-reported checked boxes do not reliably verify that a required action has in fact occurred and that data reported based on self-reported performance are not reliable and valid.

Setting an Employment Goal- The Parties have agreed to a CI for setting employment goals and including the goal(s) in the ISP(s). With recognition that some individuals are not able or interested in working, the Parties agreed, and the Court approved a CI that sets the expectation that 50% of all adults between the ages of 18-64 who are on a HCBS waiver will have an employment goal. -Using the agreed upon methodology which considers all individuals regardless of whether they express an interest in or have conditions that preclude employment, the percentage of individuals with an employment goal included in their ISPs is reported by the CSBs as only 28% (CSB report on Employment Discussions and Goals dated June 2021) compared to 30% in 2020. This independent study determined that 28 percent of individuals in the study sample had an employment goal, compared to 21% in our 2020 study. Our findings related to employment goals for this nineteenth period study agrees with the percentage reported by the CSBs.

However, ***Table 1*** shows data of the goals that have been set for the number of individuals ***who expressed an interest in employment***. Of the thirty-nine individuals in the sample who expressed an interest in employment; only twenty-eight (72%) had an employment goal in their ISPs.

The SCQR methodology established by DBHDS DQV does not include an exact question about whether an employment goal is present in the ISP. Rather the related SCQR question is whether the CM facilitated employment. The result for this question is that CSB Supervisors found evidence of this facilitation in 93% of the records and the CQI staff agreed for 72% of the records. This percentage is so much higher than the percentages in either the DBHDS Semiannual Employment Report for June 2021 or our IDA Study for the presence of an employment goal that it does not seem to be examining the same indicator. Indeed, DBHDS clarified that the number in this report includes records where facilitation occurred; where the individual was already employed; or where the individual was not interested. DBHDS is interested in determining whether the correct action was taken based on the individual's preference. The results DBHDS shared indicate 65.5% of the sample were not interested in

employment. As we have stated elsewhere it cannot be determined how CMs decide an individual is not interested in employment since there is not consistent evidence of meaningful discussions or education occurring so the individual and family can make a more informed decision.

However, we cannot compare the SCQR findings regarding goals to our findings in the IDA Study because the SCQR questions are not specific to goals but to facilitating employment and CE services. We interviewed the CQI staff, but they did not create the questions or technical guide and did not have any interpretive guidance for these specific questions. This is discussed in greater detail in the 2021 Review of the IDA Requirements of the Settlement Agreement Report for the 19th Period.

Interest in Employment and Plans to Educate Individuals and Families - The interest of the individual or family is noted only by a checked off box on the ISP. Often it is noted if it is the family who objects. We found evidence of only a few families who have strong objections to either employment and/or CE in this study. (These individuals are noted in the Tables with one asterisk). Of the individuals who were not interested, eighteen had chosen to retire and seven have medical or physical conditions that may preclude work. Overall, only 39% (39) of the individuals expressed an interest in employment and 61% (61) expressed that they did not have interest at this time. This is an increase in an interest in employment since the previous study when only twenty-six (26%) individuals expressed an interest in employment.

The Commonwealth's and CSB policy require employment to be the first and priority service option for individuals' day service option. To be the priority service option, this study expects that, at a minimum, educational plans would be developed for those individuals who are not interested in employment, unless an educational plan was unnecessary. We determined that an educational plan was unnecessary for individuals who had previously worked or volunteered and wanted to retire, and for those individuals who had significant medical and/or physical challenges that affected their interest and seemed a legitimate reason for them to not want to consider employment.

Of the remaining individuals who were not interested in employment, only 15% (6 of 39) individuals have a plan to further educate them about employment, compared to 18% who had a plan in 2020. Upon further review of the records, CMs had implemented the plans to educate individuals and

families for all six individuals who were not interested. Neither the CSBs or the SCQR report on this element but it seems important data for DBHDS and the CSBs to have to determine how to effectively educate more individuals and families about the benefits of employment and CE to encourage and increase participation.

Identifying and Addressing Barriers – For the individuals in the sample studied, CMs did a good job of identifying barriers to employment for individuals on their caseload. Overall, 98% of the individuals had barriers identified in their ISPs, compared to 78% in 2020. Individuals with medical and behavioral concerns were included in determining if barriers were present.

There is evidence that barriers are being addressed for 75% of the sixty-one individuals in the sample who had barriers identified. This is a significant increase over last year when CMs were addressing barriers for only 45% of individuals who had identified barriers. We did not include individuals in rating this category who are retired or whose teams identified that they did not have any barriers to employment. There were thirty-two individuals with no barriers to employment. The CSB self-reports and the SCQR do not report on barriers separately but include the discussion of barriers as one criterion to determine if a discussion of employment occurred.

It is excellent, and important progress, that almost all teams are identifying barriers and that so many individuals do not have any barriers to becoming employed. However, teams must become proficient developing specific strategies to address and overcome barriers if more individuals are going to build confidence and become interested in pursuing paths to employment. The increase from 45% to 75% of teams that are addressing employment barriers is heartening. Many of the individuals in this sample participate in group day programs in congregate settings and have some work activities. These are individuals who may have fewer barriers to individualized employment and whose teams could concentrate on assisting them to understand the benefits of integrated employment and to addressing whatever barriers or hesitancies may exist that is keeping them from actively pursuing employment opportunities.

Community Engagement Discussions and Goal Setting

Table 2 summarizes by CSB this study's findings for the Community Engagement expectations. This includes discussing CE; determining the individual's interest; identifying and addressing barriers to community engagement; setting community engagement goals and planning to further educate individuals who are not currently interested in CE about its benefits. The Table compiles and displays information for each Region's sample and an aggregate total of compliance for each element for each Region, and for the entire sample.

TABLE 2: Community Engagement Summary									
	CE Discuss.	Interest	Plan To Educate	Plan Implement	Goals Set	Indent. Barriers	Address. Barriers	F2F Assess.	F2F vs Total
REGION 1 (WESTERN)									
WR1	YES	YES	N/A	N/A	NO	YES	YES	YES	2 of 6
WR2	YES	YES	N/A	N/A	YES	YES	YES	YES	1 of 8
WR3	NO	NO	NO	NO	N/A	YES	YES	YES	3 of 12
WR4	YES	YES	N/A	N/A	NO	YES	YES	YES	3 of 8
WR5	YES	YES	N/A	N/A	YES	YES	YES	YES	8 of 11
WR6	YES	YES	N/A	N/A	YES	YES	YES	NO	0 of 3
WR7	NO	NO	NO	NO	N/A	YES	YES	YES	3 of 7
WR8	YES	YES	N/A	N/A	YES	YES	YES	YES	4 of 7
WR9	YES	YES	N/A	N/A	YES	YES	YES	YES	8 of 12
WR10	YES	YES	N/A	N/A	NO	YES	YES	NO	0
WR11	YES	YES	N/A	N/A	NO	YES	YES	YES	2 of 11
WR12	NO	YES	N/A	N/A	NO	YES	YES	YES	5 of 11
WR13	YES	YES	N/A	N/A	YES	YES	YES	YES	9 of 10
WR14	YES	YES	N/A	N/A	YES	YES	YES	YES	3 of 10
WR15	YES	NO	NO	NO	N/A	YES	YES	YES	4 of 10
WR16	YES	YES	N/A	N/A	YES	YES	YES	YES	2 of 9
WR17	YES	YES	N/A	N/A	NO	YES	YES	YES	4 of 5
WR18	YES	YES	N/A	N/A	NO	YES	YES	YES	7 of 12
WR19***	NO	NO	N/A	N/A	N/A	YES	YES	YES	8 of 8
WR20	YES	YES	N/A	N/A	YES	YES	YES	YES	3 of 11
WR21	YES	YES	N/A	N/A	YES	YES	YES	YES	2 of 12
WR22	YES	YES	N/A	N/A	NO	YES	YES	YES	3 of 11

WR23	YES	YES	N/A	N/A	YES	NONE	N/A	YES	8 of 12
REGION COMPLIANCE %	83%	83%	0%	0%	58%	100%	100%	96%	22%
ACTUAL NUMBER	19 of 23	19 of 23	0 of 3	0 0f 3	11 of 19	23 of 23	22 of 22	22 of 23	5 of 23

	CE Discuss.	Interest	Plan To Educate	Plan Implement	Goals Set	Indent. Barriers	Address. Barriers	F2F Assess.	F2F vs Total
REGION 2 (NORTHERN)									
NR1	YES	YES	N/A	N/A	YES	NONE	N/A	YES	0 of 4
NR2	YES	YES	N/A	N/A	YES	YES	YES	YES	0 of 4
NR3	YES	YES	N/A	N/A	YES	YES	YES	YES	1 of 10
NR4	YES	YES	N/A	N/A	YES	NONE	N/A	YES	3 of 12
NR5	YES	YES	N/A	N/A	YES	YES	YES	YES	3 of 8
NR6	YES	YES	N/A	N/A	YES	YES	YES	YES	1 of 6
NR7	YES	NO	NO	NO	N/A	NONE	N/A	YES	0 of 6
NR8	YES	YES	N/A	N/A	YES	NONE	N/A	YES	0 of 2
NR9	YES	YES	N/A	N/A	YES	YES	YES	YES	3 of 12
NR10	YES	YES	N/A	N/A	NO	YES	YES	YES	1 of 1
NR11	YES	YES	N/A	N/A	YES	NONE	N/A	NO	0
NR12	YES	YES	N/A	N/A	YES	NONE	N/A	YES	2 of 9
NR13	NO	YES	N/A	N/A	NO	NONE	N/A	YES	3 of 12
REGION COMPLIANCE %	92%	92%	0%	0%	83%	100%	100%	92%	23%
ACTUAL NUMBER	12 of 13	12 of 13	0 of 1	0 of 1	10 of 12	13 0f 13	6 of 6	12 of 13	3 of 13

	CE Discuss.	Interest	Plan To Educate	Plan Implement	Goals Set	Indent. Barriers	Address. Barriers	F2F Assess.	F2F vs Total
REGION 3 (SOUTHWEST)									
SW1	YES	YES	N/A	N/A	NO	NONE	N/A	YES	3 of 11
SW2	YES	YES	N/A	N/A	YES	NONE	N/A	YES	3 of 12
SW3	YES	YES	N/A	N/A	YES	NONE	N/A	YES	1 of 11
SW4	YES	YES	N/A	N/A	NO	YES	YES	YES	11 of 12
SW5	NO	NO	NO	NO	N/A	NO	NO	YES	3 of 10
SW6	NO	NO	NO	NO	N/A	NONE	N/A	YES	1 of 10
SW7	YES	YES	N/A	N/A	YES	NONE	N/A	YES	2 of 6
SW8	YES	YES	N/A	N/A	YES	YES	YES	YES	1 of 12
SW9	NO	NO	NO	NO	N/A	YES	YES	YES	3 of 9
SW10	NO	NO	NO	NO	N/A	YES	NO	YES	3 of 12
SW11	NO	NO	NO	NO	N/A	YES	NO	YES	5 of 12
SW12	YES	NO	NO	NO	N/A	YES	NO	YES	2 of 10
SW13	YES	YES	N/A	N/A	YES	NONE	N/A	YES	4 of 12
SW14	YES	YES	N/A	N/A	YES	NONE	N/A	YES	4 of 12
SW15	YES	YES	N/A	N/A	NO	NONE	N/A	YES	1 of 12
SW16	YES	YES	N/A	N/A	NO	YES	YES	YES	5 of 12
SW17	YES	NO	NO	NO	N/A	NONE	N/A	YES	4 of 12
SW18	YES	NO	NO	N/A	N/A	NONE	N/A	YES	1 of 10
SW19	YES	YES	N/A	N/A	YES	NONE	N/A	YES	1 of 10
SW20	NO	NO	NO	NO	N/A	YES	NO	YES	1 of 9
SW21	NO	NO	NO	NO	N/A	NONE	N/A	YES	3 of 12
SW22	NO	NO	NO	NO	N/A	YES	YES	YES	2 of 12
SW23	NO	NO	NO	NO	N/A	YES	YES	YES	9 of 12
SW24	NO	NO	NO	NO	N/A	NONE	N/A	YES	8 of 12
REGION COMPLIANCE %	58%	46%	0%	0%	64%	96%	55%	100%	58%
ACTUAL NUMBER	14 of 24	11 of 24	0 of 13	0 of 13	7 of 11	23 of 24	6 of 11	24 of 24	14 of 24

	CE Discuss.	Interest	Plan To Educate	Plan Implement	Goals Set	Indent. Barriers	Address. Barriers	F2F Assess.	F2F vs Total
REGION 4 (CENTRAL)									
CR1	NO	NO	NO	NO	N/A	NONE	N/A	YES	1 of 10
CR2	NO	NO	NO	NO	N/A	YES	NO	YES	1 of 12
CR3	YES	YES	N/A	N/A	NO	YES	NO	YES	3 of 12
CR4	YES	YES	N/A	N/A	YES	YES	YES	YES	2 of 12
CR5	NO	NO	NO	NO	N/A	NONE	N/A	YES	2 of 12
CR6	NO	NO	NO	NO	N/A	YES	NO	YES	3 of 12
CR7	NO	NO	NO	NO	N/A	NONE	N/A	YES	1 of 11
CR8	NO	NO	NO	NO	N/A	NONE	N/A	YES	1 of 6
CR9	NO	NO	NO	NO	N/A	NONE	N/A	NO	0
CR10	NO	NO	NO	NO	N/A	NONE	N/A	YES	1 of 12
CR11	YES	YES	N/A	N/A	YES	NONE	N/A	YES	2 of 12
CR12	NO	NO	NO	NO	N/A	NONE	N/A	YES	5 of 12
CR13	NO	NO	NO	NO	N/A	NONE	N/A	YES	3 of 12
CR14	YES	YES	N/A	N/A	YES	YES	YES	YES	1 of 10
CR15	YES	YES	N/A	N/A	NO	YES	YES	YES	1 of 9
CR16	YES	YES	N/A	N/A	NO	YES	NO	YES	3of 11
CR17	NO	YES	N/A	N/A	NO	YES	NO	YES	1 of 11
CR18	YES	YES	N/A	N/A	YES	NONE	N/A	YES	2 of 11
CR19	NO	NO	NO	NO	N/A	NONE	N/A	YES	3 of 11
REGION COMPLIANCE %	37%	42%	0%	0	50%	100%	37%	95%	47%
ACTUAL NUMBER	7 of 19	8 of 19	0 of 11	0 of 11	4 of 8	17 of 19	3 of 8	18 of 19	9 of 19

	CE Discuss.	Interest	Plan To Educate	Plan Implement	Goals Set	Indent. Barriers	Address. Barriers	F2F Assess.	F2F vs Total
REGION 5 (EASTERN)									
ER1	NO	NO	NO	NO	N/A	NONE	N/A	YES	7 of 12
ER2	NO	YES	N/A	N/A	YES	NONE	N/A	YES	3 of 12
ER3***	YES	NO	N/A	N/A	N/A	N/A	N/A	YES	2 of 12
ER4***	YES	NO	N/A	N/A	N/A	N/A	N/A	YES	7 of 11
ER5	NO	NO	NO	NO	N/A	NONE	N/A	YES	2 of 11
ER6	NO	YES	N/A	N/A	YES	NONE	N/A	YES	2 of 11
ER7	NO	NO	NO	NO	N/A	YES	YES	NO	0
ER8	YES	YES	N/A	N/A	YES	YES	YES	YES	1 of 11
ER9	NO	BLANK	NO	NO	N/A	NONE	N/A	YES	2 of 11
ER10	NO	NO	NO	NO	N/A	NONE	N/A	YES	3of 12
ER11	NO	NO	NO	NO	N/A	NONE	N/A	YES	2 of 8
ER12	NO	NO	NO	NO	N/A	NONE	N/A	YES	1 of12
ER13	YES	YES	N/A	N/A	YES	NONE	N/A	NO	0
ER14	NO	YES	N/A	N/A	NO	NONE	N/A	YES	1 of 12
ER15	NO	YES	N/A	N/A	YES	NONE	N/A	YES	2 of 12
ER16	YES	YES	N/A	N/A	NO	NONE	N/A	YES	2 of 12
ER17	NO	NO	NO	NO	N/A	NONE	N/A	YES	1 of11
ER18	YES	YES	N/A	N/A	YES	YES	YES	YES	0 of 11
ER19	YES	YES	N/A	N/A	YES	YES	YES	YES	7 of 12
ER20	NO	NO	NO	NO	N/A	NONE	N/A	NO	0
ER21	NO	NO	NO	NO	N/A	NONE	N/A	NO	0
REGION COMPLIANCE %	33%	43%	0%	0%	78%	100%	100%	81%	43%
ACTUAL NUMBER	7 of 21	9 of 21	0 of 10	0 of 10	7 of 9	19 of 19	4 of 4	17 of 21	9 of 21
TOTAL COMPLIANCE %	59%	60%	0%	0%	66%	100%	80%	93%	40%
TOTAL %	59 of 100	59 of 99	0 of 38	0 of 38	39 of 59	97 of 97	41 of 51	93 of 100	40 of 100

KEY:
* AR does not want community engagement
*** Too medically involved/unstable

Community Engagement Discussion - DBHDS set a goal in the Outcome-Timeline submitted to the Court in January 2016 that 100% of individuals would have an annual discussion about CE. More recently the Parties agreed that 86% of all individuals in the HCBS waivers would have an annual discussion about CE. The reduction to 86% allowed that not all obstacles to including discussions for some individuals will be resolved. Our study found that minimally sufficient discussions were held for 59% of the sample. In our 2020 and 2019 Study samples respectively, we found that 52% and 74% of the individuals had such discussions. The percentage of compliance across the five Regions ranged from 33% in Region 5 to 92% in Region 2. As was true for employment, we expected to find evidence of meaningful discussions that at a minimum included discussing the services available, and the individual's skills, interests, challenges and barriers in order to find that a sufficient discussion occurred. The CSB Supervisor SCQR of records reported 96% and the CQI review agreed with 92% of the regional SCQR findings. This is somewhat curious. The CSB Annual Report of CE Discussion and Goals reports that CMs had discussions for 93% of the individuals on their caseloads. It is not explained how the CM Supervisors found a higher percentage of evidence of these discussions. This percentage difference between the SCQR and CSB Annual Report is within the margin of error.

We found the same interpretive guidance for the SCQR question about CE discussion as we did for employment. A list of criteria similar to what we consider evidence of a discussion is provided to the reviewers, but the reviewer needs to find evidence of only one of these criteria being present for a decision to be made that a discussion occurred.

We found evidence of far less meaningful discussion than is required by the CI. Many CMs consider a group day program as an adequate setting to provide community involvement and engagement. If an individual only participated in large community group activities with their program peers; volunteered only a few times a month as part of a group going from the day program; or had socialization goals with peers within their group setting, we did not consider them to have been given an understanding of community engagement or to be involved in community engagement. Many CMs write about these day program experiences in progress notes as though the individual is engaged in active community integration.

Setting a CE Goal – It appears when comparing the interest in CE between the samples in our 2019, 2020 and 2021 that interest has increased slightly between 2020 and 2021 but has not reached the level of interest expressed in the sample in 2019. While the pandemic explains a lack of participation in community activities, it does not explain why a team is not forward thinking and continuing to discuss interests so they can be actively pursued once the pandemic is under control and social restrictions are lifted. It is surprising that so many individuals in the 2021 sample were uninterested in CE.

This could be the result of so few discussions to adequately explain CE; the lack of CE capacity and availability in parts of the state; and a seeming lack of some CM's understanding of the definition of CE. This lack of understanding is evidenced by the number of CMs who consider participation in group day support to provide enriching opportunities for community engagement. This observation is based on the overall outcome of, and specifics found in the record review. Many CMs continue to report that the very limited involvement individuals have in community-based group activities offered by the center-based group day providers equate to community engagement.

These activities are typically offered to more than three individuals in one group, which is the maximum number of individuals to be in inclusive activities in the community when using CE, and do not include significant or meaningful interaction with typical community members.

We expect in our study that individuals who have an interest in CE should have a goal set for CE. If they do not have an interest, we follow DBHDS' expectation that the team will develop a plan to educate them of the benefits of CE and implement this plan, which is reviewed later in this report. Using this methodology, 59% of the individuals who expressed an interest also have a CE goal (39 of 59 individuals). This compares to 55% and 69% of the sample who had goals in the 2020 and 2019 IDA Studies respectively. Regions ranged from 50% in Region 4 to 83% in the Region 2 in the number of individuals who have a CE goal. This is significantly better than last year when one Region had only 10% of its interested individuals with a CE goal.

The DBHDS SCQR process did not have a specific question as to whether there was a goal. Rather, the question was whether the CM "facilitated access to community involvement/CE/CC. In response to this question, The CSB

Supervisors found that 68% of CMs facilitated access and the CQI staff agreed with 64% of the regional findings that CMs facilitated access to CE.

The DBHDS Annual Report on CSB Community Engagement Discussion and Goals does report on goals as we do in our review of the sample. This report indicates that only 38% of individuals with ISPs in 2020 had goals. However, if we included all of the individuals (41) who did not have an interest in CE, in making the calculation, then only 39 of 100, or 39% had a goal. These findings from both the CSBs in the annual CSB CE Discussion and Employment Summary and this study seem quite discrepant from the SCQR findings of CMs facilitating community engagement for at least 64% of individuals.

Interest in CE and Plans to Educate Individuals and Families - The interest of the individual, family or Authorized Representative (AR) is noted by a check off box on the ISP. Overall, 59% of the individuals expressed an interest in CE, compared to 39% expressing an interest in employment.

Therefore, 41% of the individuals expressed having no interest in CE at this time. DBHDS expects CMs to develop educational plans to address the obstacles to individuals interested in CE, as a step to increase participation in CE. The lack of development of such plans and identification of obstacles has clearly hindered progress. We found that not a single one of the thirty-eight individuals who had not expressed an interest in CE to have any evidence of a plan to educate them of the benefits, and of course no plans were implemented. (*Three individuals in the sample were excluded from this total because their medical complications preclude them from community involvement*). This compares even more poorly to the two previous studies: fifty-seven individuals in the 2020 sample who were not interested in CE, only 4% (2) of the individuals have a plan to further educate them about CE. This is a decline since the 2019 study which found that 10% of the sample had a plan to educate the individuals/ARs further about the benefits of CE.

Many CMs record that their plan was merely to simply ask each year whether the individuals, family or AR were interested in CE. Our criteria for an acceptable education plan being in place and implemented is when the CM documented specific strategies they would use to further the individual‘s and family’s interest and comfort with and understanding of CE. CMs may achieve a higher percentage of individuals who express interest by utilizing a strategy to explore the individual’s or family’s interests as they relate to participating

in community groups, functions and activities including volunteering. Many of these individuals are attending congregate group day programs. They may already volunteer, but on a limited basis and in large groups. This volunteer work is not individualized to their interests. CMs report that group day programs offer limited weekly community outings, but few give the individuals the opportunity to substantively interact or develop relationships with others in their communities, make contributions, learn new skills or pursue interests outside of shopping, dining out and attending sporting events or concerts. The ISP teams could use this level of activity and community presence to assist individuals to transition to CE.

Identifying and Addressing Barriers - CMs identified barriers to participation in CE for 100% (97) of the individuals on their caseloads who are in the sample, compared to 68% and 76% in the 2020 and 2019 IDA Study samples respectively. This is a significant improvement and should provide the information that CMs need to assist individuals to engage in meaningful community involvement. Many individuals (46) have no barriers to participate in CE, which is another positive development. (*Three individuals in the sample were excluded from this total because their medical complications preclude them from community involvement*). CMs are addressing the barriers for 41 of the 51 (80%) individuals who had barriers identified by their teams. This is a significant improvement from the previous two studies which identified that CMs were addressing barriers for 34% of the individuals in the sample in 2020, and 43% of the 2019 sample.

To achieve the compliance measures associated with CE, it is notable that ISP teams have become more proficient in both identifying barriers and developing specific strategies to address and overcome barriers. These are essential efforts if more individuals are going to be interested in transitioning from their day programs in congregate settings to become more meaningfully engaged in their communities. Many of the individuals in this sample participate in center-based group day programs which often include some community-based activities as discussed earlier. These are individuals who may have fewer barriers to participating in CE and whose teams could concentrate on assisting them to understand the benefits of CE and addressing whatever barriers or hesitancies may exist that is keeping them from becoming engaged in community life and developing relationships with typical peers. Currently only thirty-nine individuals out of the 100 reviewed have a CE goal. Because of the COVID community safety precautions many of

these individuals were unable to actually participate in CE for most of the year.

Face to Face Assessments

The Independent Reviewer asked that we include a review of whether CMs conducted Face to Face assessments in this reporting period. We reviewed the records to determine if these assessments occurred and how many of them were actually conducted in person. As of March 2020, the Commonwealth determined that CMs should conduct these monthly and quarterly assessments using telephonic or Zoom meetings as a safety precaution during COVID. This restriction was in place for all of 2020. We reviewed progress notes from January 2020 through December 2020. We received progress notes for 93 of the 100 individuals in the sample. CMs conducted face to face assessments for all of the 93 individuals for whom we received records, which is depicted in ***Table 2 Column I.*** We also report in ***Column J*** how many were conducted in the year and of the total, how many were held in person. Of all of the face-to-face assessments, forty of the 100 individuals had an assessment conducted in every month of the calendar year. The reader can review how many of these were conducted in person. As an example, if an individual had three in-person meetings in the calendar and had twelve total F2F assessments, the data in ***Column J*** will be 3 of 12. Most face-to-face assessments that occurred between January and March 2020 were in-person. DBHDS shared progress notes for 93 of the 100 individuals in the sample. Only seven of these 93 individuals did not have evidence of any in-person face to face meetings during Calendar Year 2020. Some CSBs started to have CMs meet in person again later in the year but not all of them reinstituted this by December 2020. DBHDS did not require a return to in-person F2F assessments until October 2021 while recommending CSBs start to have CMs return to in-person assessments in July 2021.

Conclusions and Recommendations

The findings of this study do not conclude that the targets DBHDS set for both IDA discussions and IDA goals are being met. Only seventy-eight (78%) individuals had a meaningful employment discussion, and fifty-nine (59%)

individuals had a sufficient discussion of CE. The discussions of employment have increased from the 72% that occurred for the 2020 IDA Study. CE discussions increased from 52% in 2020 to 59% in 2021 but have not reached or exceeded the percentage of discussions in 2019 which was 76%. Many CMs still do not discuss employment or CE but rather only ask if there is an existing interest. In these cases, there is no evidence that the CM engaged in a discussion about available employment or CE services, interests, skills and what individuals and ARs may perceive are barriers. It is also of note that CE is not regularly discussed with or offered to individuals participating in employment, as though the availability of work alone is sufficient.

The interest in employment and CE is surprisingly low with only 39% of individuals and ARs expressing an interest in employment and 59% of individuals and ARs expressing an interest in CE. This is an increase in interest in both services from 2020 when interest was 26% in employment and 42% in CE. After decades of experiences when employment and other integrated day activities were not offered or available, especially for individuals with complex needs, individuals and ARs still need much more information about employment and integrated opportunities that are actually available in order to more seriously consider it as the best option for their family members. To view these integrated service options as a viable and beneficial for their adult children, families may need opportunities to observe other individuals with similar characteristics in these programs. CMs appear to need more education and mentoring by their supervisors to both understand and explain CE and CC services.

The findings of this study also indicate that CMs need to be more prepared to have initial discussions about the impact of wages on existing Medicaid and other benefits, so families are more comfortable seeking more information about this critical issue rather than dismissing employment as even an option at the ISP meeting. These are consistent with the findings from these reviewers' 2020 and 2019 IDA Studies. DBHDS has provided more training information about benefits, but we did not see evidence that CMs were discussing the impact of employment on individuals' benefits. The fact that there is little evidence that CMs are using the enhanced training about benefits when conducting ISP meetings is concerning. Families have legitimate concerns and questions about benefits. CMs can refer these families to Benefit Counselors. However, this entails creating an extra responsibility for families who are already expressing a lack of interest in employment for their children

with I/DD. CMs should answer the basic questions about the impact of employment on benefits. These answers will give the families a greater sense of comfort that benefits may not be negatively impacted or that the combination of wages and reduced benefits will provide greater financial security for their loved ones.

CSBs are not training or expecting the CMs to develop strategies to educate individuals who are not yet interested in employment or CE to learn more about these services. CMs have educational plans in place for only 15% and 0% respectively for individuals who are not currently interested in employment or CE. CMs need training to be able to both educate these ARs and individuals if individuals are to select IDA rather than congregate day programs that offer limited opportunities for community integration and inclusion. CSBs are not effectively implementing Virginia's Employment First Policy or the requirements of the compliance indicators.

DBHDS has developed a number of training modules regarding the IDA initiative for CMs which is discussed in these Expert Reviewer's Report to the Independent Reviewer. DBHDS reports that all CMs take the online employment training which includes aspects of CE. It is clearly apparent from a review of the 100 records in this sample that many CMs still do not grasp what options should be offered through CE. Many CMs report that individuals in congregate Group Day settings enjoy community inclusion or are receiving community engagement because the provider takes them in groups for a brief portion of their weeks at the congregate settings to community activities. However, these outings are not typically individualized; are usually done with several other program participants; and do not offer opportunities to regularly engage with typical peers or to develop relationships with people without disAbilities. This is a similar finding to that in the 2020 IDA Study.

Supervisors are most likely the key to advancing cultural change via a more consistent training process and setting clear expectations especially for CE for new CMs. Supervisors need to continue mentoring existing CMs in this area. DBHDS may want to work with the CSBs that are more proficient at achieving the discussion and goal targets to identify best practices for CM training and supervision. Training should include detailed technical training, and shadowing by supervisors for monthly visits and annual ISP meetings to offer timely technical assistance. CMs who demonstrate these competencies over time may be paired with newly hired CMs. This is especially important

because there is often frequent turnover in these positions. CMs need more training to make goals more specific and to develop measurable objectives to be able to reliably determine progress. DBHDS may want to also consider again offering in-person regional training sessions as it did when it first rolled out Employment First and Community Engagement

To make substantive progress, the lack of provider capacity to offer CE must be addressed and resolved. We found last year that there is not a sufficient number of these providers of CE services in many geographic areas of Virginia, and DBHDS has indicated existing providers report that the rates paid to deliver CE services is not adequate. No information was provided by DBHDS to suggest any improvement in these areas, although a rate analysis for CE has been completed and may suggest the need for rate increases. The combination of these factors may contribute to the reduced rate of availability and enrollment in these programs, as reported in the June 2021 Semiannual Employment Report. CMs cannot reasonably be expected to offer CE when it is not available in proximity to where individuals reside. The lack of providers may also result in CMs avoiding discussions about interest with individuals and ARs. It is positive that residential and personal care providers can assist individuals to engage in community inclusion.

It is positive that DBHDS is using a two phase SCQR process to assure an internal CSB supervisory review followed by an external review to ensure that the CSB CMs understand how to have, and actually do have, sufficient discussions, which lead to identifying obstacles, creating goals, and developing education strategies about IDA for individuals who express not having a current interest in these services. The DBHDS was able to share a draft report of the findings of these reviews but no recommendations. The SCQR does not inquire as to employment or CE goals nor does it query about interest, identification of barriers or education plans to address employment and CE when there is a lack of interest by an individual or AR. Without these inquiries the current SCQR process is inadequate in determining adherence to the Commonwealth's commitments.

We again recommend that CSBs and CMs may benefit if minor changes are made to the forms used for the ISP and Quarterly Reviews. First, not all of the CSBs use the newest ISP form. Second, there is no space on the form or a requirement that the CM summarize what they actually discussed about employment and CE services. Barriers are noted through a check off section,

but the CM does not need to note how they are being addressed, except to list services that MAY address the barriers. Even when these services are checked off as being options to address barriers, they are not always included as services or goals in the ISP.

This review found that CMs did a better job suggesting options to address barriers and following through. Many CMs still note a family or individual does not want employment without seemingly exploring with them what brings them to the conclusion that they do not want to pursue employment. Effective implementation of the Commonwealth's Employment First policy requires that the team determines the cause of their reluctance so a plan can be developed to educate them when they express that they are not interested in these services. The Quarterly Reviews expect the CM to note if community inclusion goals and employment goals are on track, but a simple Yes/No format is used. Therefore, the CM does not provide any actual quantitative data or qualitative information to support their determinations.

The newest ISP form includes a section after Employment titled: *Alternatives to Work*. The questions asked in this section are solely about volunteering. There is still no section that pertains directly to community engagement other than for the CM to check the boxes that this service was discussed and whether the individual is interested. Because of the focus on volunteering, it cannot be determined if CMs discuss other aspects of CE services. This confirms the need for greater education about CE for Case Managers, individuals and families. This remains an unresolved issue from 2020.

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October 20, 2021

APPENDIX C

TRANSPORTATION

By

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Consortium on Innovative Practices

Period 19 - Compliance Indicators: Transportation

Ric Zaharia, Ph.D.

October 30, 2021

Exec Summary

In its last review DMAS confronted the challenge to assess additional or alternative metrics for 'reliable transportation'. While it continued performance-based metrics which rely on reported complaints per ride, it identified potential new measures that directly address encounter-based trip times to generate a measure of on-time performance. On-time performance metrics are a truer measure of reliability than user complaints. These performance measures are expected to be available for review early in 2022.

DMAS efforts in the year since the 17th Period, included focus groups, which were not held during the last review. Two have been held and yielded constructive feedback during the 19th Period. DMAS has sustained all other compliance activities and outcomes during this Period. The 17th Period review determined that the Commonwealth had achieved compliance indicators 16.01, 16.03, 16.04, 16.05, and 16.07. It had not achieved 16.02, 16.06, or 16.08.

Although DBHDS has not yet achieved the **annual** benchmark of 86% user positive ratings for non-NEMT transportation (i.e., IDD waiver agency provided transportation), its Quality Service Review contractor, HSAG, has reported that over 90% of those interviewed with agency provided transportation reported having no problems over two interview cycles in the first half of FY22.

The 19th Period study determined that the Commonwealth has now Met six of the eight compliance indicators for the transportation provision III.C.8.a. (16.01, 16.03, 16.04, 16.05, 16.06 and 16.07.) It had not achieved 16.02 or 16.08.

Introduction

The Independent Reviewer's 17th Report to the Court, requested that "the Commonwealth provide a valid measure regarding the receipt of NEMT reliable transportation for Waiver users" (16.02). From the 17th Report:

> *…. the extremely low percentage of filed complaints does not accurately represent the full scale of what is a vexing transportation reliability issue. The number and percentage of "complaint free" trips is not a valid measure of transportation reliability…. the lack of a filed complaint is not a valid measure that reliable transportation was provided…. The DMAS plan to 'install trip encounter billing' may be a vehicle for measuring most accurately "reliable transportation." pp. 55-56*

DMAS is achieving success with all indicators except this one, which requires identifying alternative metrics for "reliable" transportation.

For this review I interviewed key DMAS leadership and reviewed twenty plus documents that DMAS felt showed evidence of their compliance with their seven compliance indicators.

19th Period Review

DMAS's largest and only fee-for-service NEMT provider, LogistiCare, changed its name to ModivCar in April 2021. Six MCOs now provide acute care, NEMT transportation as part of their capitation rate; they provide about 5% of the DMAS trips on behalf of individuals with IDD.

DMAS has explored alternative measures for 'reliable transportation' and has settled on a trip-based billing encounter metric that, while initially manual, will eventually be digitized. DMAS has drafted a specific "scheduled vs actual" trip measure. DMAS projects that this on-time performance measure will be complemented over the next few months by a) full actualization of the GPS trip system and b) a user rating App like that used by Uber or Lyft, which will allow for real time late notifications, rider alerts, and driver ratings. This latter strategy is encouraged by DMAS's success implementing an App-based gas reimbursement system, making that option extremely easy and accessible to family and friends who must transport. DMAS willingness to innovate for continuous improvement in this area is acknowledged.

Regional Advisory Boards continued as remote meetings; some appeared to suffer from poor attendance. MCO transportation advisory boards appear to be subsumed under larger consumer advisory committees to the managed care entity.

DMAS conducted focus groups in December 2020 and March 2021. Additional groups are planned, since DMAS has found the focus group approach to be useful. Participants were representative of those receiving transportation services, and several significant issues were raised. This may be an emerging continuous improvement strategy that DMAS can use effectively to solicit and clarify feedback on system performance.

The Commonwealth's current contractor, HSAG's (Health Services Advisory Group's), Quality Service Review (QSR) tool includes three questions regarding transportation during the individual interviews of the Person-Centered Review. Although DBHDS has not yet reported an **annual** percentage of user positive ratings for non-NEMT transportation (i.e., IDD waiver agency provided transportation) HSAG has reported that over 90% of those interviewed with waiver agency provided transportation as having "no problems" over two interview cycles.

Compliance Tables

VA #	III.c.8.a – Indicators	Facts verified	Analysis	Status
16.01	1. The Commonwealth includes performance standards and timeliness requirements in the Medicaid non-emergency medical transportation (NEMT) contracts including those services for the DD waiver recipients. The Commonwealth will take action against Fee for Service NEMT transportation vendors and managed care organizations that fail to meet performance standards or contract requirements, which may include liquidated damages or fines.	DMAS fined its fee for service contractor, ModivCar, $257,000 during FY21 for not meeting contract performance standards, such as "unfulfilled trips"; six managed care entities were fined $92,500 during Q4 FY21 (see #2).	DMAS has complied with this indicator over 2 review cycles.	17th MET 19th MET
16.02	2. At least 86% of DD Waiver recipients using Medicaid non-emergency medical transportation (NEMT) will have reliable transportation.	In Q2 FY21 ModivCar's IDD complaints were 4 per 1,000 trips versus 1.5 per 1,000 for all six MCO's, who drove 5% of total NEMT miles for IDD during this quarter. (See #10) DMAS is assessing an alternative measure of reliability which will yield more precise trip-specific performance data (see #27). This on-time performance measure will be based on billing encounter data, including scheduled v actual time.	DMAS transition to an encounter-based on-time performance measure can be accomplished before the next review period.	NOT MET
16.03	3. The Commonwealth will include in contracts with the Fee for Service (FFS) NEMT for DD Waiver services and managed care transportation vendor(s) (for acute and primary care services) requirements to: a. Separate out DD Waiver users in data collection, reporting, and in the quality improvement processes to ensure that transportation services are being implemented consistent with contractual requirements for the members of the target population;	DMAS issued an RFP in 2018 (#7), which is incorporated by reference in all contracts (see #3-6); the RFP specifically requires (p.14) separating out DD users in all data collection, reporting and quality improvement.	DMAS and contractors have complied with this indicator over 2 review cycles.	17th MET 19th MET
16.04	b. Ensure DD Waiver users and/or their representatives have opportunities to participate in the regional Advisory Board; and	Advisory Board minutes show information exchanges regarding vendor issues, response to individual issues, and use of transportation care	DMAS contractors offer IDD Waiver users opportunities to participate in these Advisory Boards. Remote tele-meetings	17th MET 19th MET

VA #	III.c.8.a – Indicators	Facts verified	Analysis	Status
		coordinators (see#11-17). Some Advisory Boards appeared to suffer from poor attendance, and some were subsumed under larger consumer advisory committees for the whole MCO.	may have encouraged involvement due to representatives not having to travel to a site for a meeting. However, poor attendance may be a future issue. DMAS and contractors have complied with this indicator over 2 review cycles.	
16.05	c. Through a statistically valid sample of transportation users, surveys are conducted to assess satisfaction and to identify problems on a quarterly basis.	All contract providers conducted quarterly sample surveys of IDD users (see #11-17). These surveys do surface timeliness issues on some rides (2-3%) but generally indicate user satisfaction with service. DMAS has verified the statistical sampling strategies.	DMAS has complied with this indicator through 2 review cycles.	17th MET 19th MET
16.06	4. DMAS transportation operations will conduct focus groups as needed as determined by DMAS with the DD Waiver population receiving FFS and managed care transportation in order to identify, discuss, and rectify systemic problems.	DMAS conducted remote focus groups on 12.16.20 and 3.31.21; numerous issues were raised by participants. (See #8-9, #26). Additional focus groups are planned.	DMAS transportation leadership facilitated these focus groups, which optimizes the likelihood that systemic issues will be addressed. Given that these are at DMAS discretion, DMAS has complied with this indicator.	17th NOT MET 19th MET
16.07	5. DMAS provides all Medicaid recipients with information on processes for filing complaints or appeals related to their Medicaid services.	DMAS posts a link to Logisticare's (now ModivCar) member handbook on transportation (See #18). Likewise, MCO handbooks, including transportation complaints, are posted on	Users who are IDD are not shy about filing formal complaints: about 16 complaints a day were filed during this 6-month period. DMAS has complied	17th MET 19th MET

VA #	III.c.8.a – Indicators	Facts verified	Analysis	Status
		their websites (see #28). Appeal forms are also posted on DMAS website. (See #19) ModivCar received 1,057 IDD complaints in Q3 FY21 and 1054 complaints in Q2 FY21 (see #10, #20).	with this indicator for two reviews.	
16.08	6. As part of the person-centered reviews conducted through the Quality Service Review (QSR) process, the vendor will assess if transportation provided by waiver service providers (not to include NEMT) is being provided to facilitate individuals' participation in community activities and Medicaid services per their ISPs. The results of this assessment will be included in the QSR annual report presented to the Quality Improvement Committee (QIC). At least 86% of those reviewed report that they have reliable transportation to participation in community activities and Medicaid services.	The Commonwealth's contractor HSAG's Quality Service Review tool included three specific questions regarding transportation during the individual interviews. Round 1 of the QSR reported 90% of the individuals interviewed experienced no transportation problems (#25). In Round 2 HSAG interviewed 1088 individuals who receive transportation from their waiver service provider; of these 1088 (unduplicated) 94 reported one or more problems with transportation and 994 reported no problem resulting in a 91% positive rating, which can serve as a proxy for reliable transportation (see #21-24). This is comparable to the 93% rate ModivCar user samples reported (210/227 for Q4 FY21) for timeliness problems in their monthly consumer surveys (see #11)	The QSR contractor, HSAG, has reported over two interview cycles over 90% of users having no problem with the transportation provided by their waiver provider. If sustained and included in the QSR annual report to the QIC, DBHDS will be in compliance with this indicator. (Note: The DBHDS measure statement for this indicator is confusing [see #22]. The 'number of providers marked Yes as to providing transportation' divided by 'the number of interviewees' does not produce a measure of reliable transportation. A second part is needed in the measure with the numerator of 'Number reporting no problems with waiver provider').	NOT MET

Recommendations

1) DBHDS should finalize and implement metrics that assess on-time performance based on billing encounter data.

2). DMAS should consider continuing Regional Advisory Boards via Remote tele meetings.

3) DMAS should consider institutionalizing a once per year "How Are We Doing" focus group for the purpose of identifying continuous improvement activities.

Acronyms

DMAS – Department of Medical Assistance

DBHDS – Department of Behavioral Health and Developmental Services

NEMT - Non-Emergency Medical Transportation

IDD – Intellectual/Developmental Disability

HSAG – Health Services Advisory Group

MCO – Managed Care Organization

QSR – Quality Service Review

RFP – Request for Proposal

Attachment 1
Documents Reviewed

Transportation – Title or BOX Filename

1. 16.01 - 2Q2021 Total Complaint Summary
2. 16.01 - ModivCar FFS NEMT Q4 SLA Amounts Transportation
3. 16.03 - 4.4.2 VA Transportation Provider Agreement
4. 16.03 - Contract 10041_Final Executed (includes BAA)
5. 16.03 - Contract 10041 Mod 2 OY Renewal_1_Fully Executed
6. 16.03 - Contract 10041 Modification 1 Executed 12.20.18
7. 16.03 - RFP 2018-01 NEMT Final 092017(002)
8. 16.06 - 2021 03-31 Transportation Focus Group Meeting Minutes (2)
9. 16.06 - 2021 3-31 Transportation Focus Group Agenda (1)(1)
10. 16.07 - 2Q2021 DMAS IDD-FFS and MCO Total Complaint Report Summary (1).
11. Fee For Service NEMT Reports (ModivCar)
12. Aetna MCO Reports
13. Anthem MCO Reports
14. VA Premier MCO Reports
15. United Health Care MCO Reports
16. Optima MCO Reports
17. Magellan MCO Reports
18. LogistiCare Member Handbook for NEMT, 4/19 (https://www.dmas.virginia.gov/media/2717/member-handbook-apr2018.pdf)
19. Virginia Medicaid Appeal Request Form, 6.19 (dmas.virginia.gov)
20. ModivCar Solutions…. DMAS Summary ID-DD Complaints, Apr-June 2021
21. 2021__QSR_Aggregate_QSR Report_R2FY2021_081621
22. 36.4,36.5,37.1,37.5,37.7 Transportation…7.6.21 (Measure Language
23. QSR Round 2 HSAG PCR Results…9.20.21
24. PCR_Round 2 Individual Data_081621….
25. QSR Aggregate Report R1 FY2021 March 2021
26. 2020 12-16 Transportation Focus Group Meeting Minutes
27. Draft (10.1.21) – Proposed DMAS Performance Measure
28. Email, Bevan to Zaharia, 10.15.21

Attachment 2
Interviews

Name	Title	Date
Ann Bevan	Director, Division of High Needs Support, DMAS	10.1.21
Bill Zieser	Manager, Transportation Management Services Unit, DMAS	10.1.21
Jenni Schodt	Settlement Agreement Director, DBHDS	10.1.21 10.8.21
Heather Norton	Assistant Commissioner, Developmental Services, DBHDS	10.8.21

APPENDIX D

REGIONAL SUPPORT TEAMS

By

Ric Zaharia Ph.D.

Consortium on Innovative Practices

Period 19 - Compliance Indicators
Regional Support Teams (RST)

Ric Zaharia, Ph.D.

November 8, 2021

Executive Summary

There are currently fifteen DBHDS staff positions assigned to Provider Development for regional oversight and guidance. Although the RST timeliness benchmark of 86% has not yet been attained, when circumstances outside of CSB control (provider or individual moved without advance notification of case manager) were removed, timeliness rates improved significantly. DBHDS placed six CSBs on its Watch List for RST performance during FY21.

Data quality planning, monitoring and assessment appear well evolved within the Provider Development section. Data quality here has been an area of major emphasis and progress over the past few years. DBHDS has identified residual weaknesses in reliability and reports that corrective actions are in place where it has determined it feasible to improve data integrity. However, DBHDS's Office of Data Quality and Visualization has not assessed the RST data source and found that previous data quality threats have been remedied and that the RST data are now reliable and valid and available for compliance reporting.

Introduction

During the 17th period DBHDS reported 80% system compliance in timely RST referrals, although three CSBs consistently failed to meet the benchmark. Adherence to this indicator showed progressive improvement over earlier quarters in FY20. DBHDS did not require CAPs of CSBs for RST referral problems until October 2020. However, DBHDS provided technical assistance, training, and notification efforts. DBHDS initiated sending quarterly RST feedback letters to CSBs. These also served as reminders of those in more restrictive settings.

The 17th period review found that provider development and support efforts had been expanded including the Jump Start funding program, provider designations, Provider Readiness Education Program (PREP), and participation in the Charting the LifeCourse.

In his 17th Report to the Court, the Independent Reviewer determined that the Commonwealth had maintained Sustained Compliance for provisions III.E.1-3. He also determined that DBHDS had not met the requirements of Provision III.D.6. and its compliance indicators 20.02, 20.04, 20.05, 20.06 and 20.07. He reported not being able to determine whether the Commonwealth's achieved the RST compliance indicators 20.01, 20.03, 20.08, 20.09, 20.10, and 20.13.

Period 19th Review:

For this study during the 19th period, I reviewed over forty documents and interviewed the Director of Provider Development/CMSC Chair.

Based on my review, DBHDS continues efforts to comply with the indicators related to Regional Support Teams and has increased resources to the community regional consultant effort. There are currently 15 staff positions assigned to Provider Development for regional oversight and guidance.

DBHDS reports that over the year (FY21) timeliness rates among 516 non-emergency referrals ranged from a low of 59% to a high of 72%. These do not meet the target of 86%. As previously reported, achieving the RST can only be accomplished when all CSBs ensure that their case managers contribute effectively. In addition, when circumstances outside the CSBs' direct control (provider or individual moved without notification of case manager) are removed from the calculation, the referral CSB timeliness rates improved to a range of 81% to 94%. If the Commonwealth is to achieve this metric, DBHDS will need to continue to intervene when CSB's do not fulfill their responsibilities and focus on providers who admit or transfer individuals without case manager notification or ISP team involvement. In many cases providers make unilateral decisions that are not team based and are not person-centered.

DBHDS continues to provide training and technical assistance to CSBs on RST referral requirements and continues to send quarterly RST feedback letters to CSBs, which also serve as reminders of those in more restrictive settings. DBHDS informs CSBs through an annual performance letter from the CMSC that a CAP is required if their RST referrals were non-compliant. Six CAPs were submitted and approved for Q1-2FY21. Those CSBs were also placed on the DBHDS Watch List for RST performance.

This review confirmed that provider development and support efforts continue, including the Jump Start funding program, provider designations, provider preparation for expansion/development, and participation in the Charting the LifeCourse, which is aiding DBHDS in its shift to a person- and family-centered service system. This review of DBHDS documents and interviews also verified that DBHDS has tracked data, conducted quarterly assurance reviews, conducted data analysis, assigned CRCs, used RST data to identify gaps, and identified individuals who chose less integrated residential settings over the past two review cycles.

RST data quality has been an area of major emphasis and progress over the past few years. Data quality planning, monitoring and assessment have improved significantly within the Provider Development section. DBHDS has revised the RST referral form at least twice during the past two review cycles, has improved CSB understanding and participation in the RST process, has instituted an effective look-behind process on the usage of waiver slots to identify individuals not properly referred, and has refined its data analysis tools to better determine gaps in the service delivery system and CSB/provider adherence to reporting requirements.

Weaknesses in reliability have been identified and correction actions are in place or planned where feasible to improve data integrity. Foremost, among these actions is the planned incorporation of the RST referral process in WaMS. The DBHDS Office of Data Quality and Visualization's assessment of the RST data has not yet found that the RST source provides reliable and valid for compliance reporting.

The 19th Period study determined the Commonwealth has made substantial progress. For the RST provisions: this review confirmed facts that demonstrate that the Commonwealth has a continued to fulfill the requirements for III.E.1-3 and has achieved ten of thirteen compliance indicators for provision III.D.6. The Commonwealth has achieved indicators 20.01, 20.03, 20.04, 20.05, 20.06, 20.08, 20.09, 20.10, 20.11, 20.03; and has not met 20.02, 20.07, and 20.12.

Compliance Indicator Tables

VA #	III.D.6 - RST	Verified Facts	Analysis	Status
20.01	1. DBHDS tracks on a statewide level whether referrals to RSTs are submitted in accordance with the DBHDS RST Protocol and the timeliness of referrals to the RSTs, as specified in the DBHDS RST Protocol.	This review confirmed that DBHDS has continued to track and report quarterly on RST referrals and adherence with RST protocols, including timeliness (see #2-4, #35-36).	DBHDS has complied with this indicator for two review periods.	17th- Status undetermined (UD) 19th -MET
20.02	2. DBHDS is in compliance with the agreement when 86% of all statewide non-emergency referrals, as such referrals are defined in the DBHDS RST Protocol, meet the timeliness requirements of the DBHDS RST Protocol.	DBHDS reported RST FY21 timeliness rates as: 64%-Q1 60%-Q2, 59%-Q3 72%-Q4 e.g., in Q4 out of 159 non-emergency referrals, 115 were timely including those outside of CSB control. In Q4 FY20 of 40 CSBs 32 met the 86% benchmark and in Q4 FY 21 out of 40 CSBs 34 met the 86% benchmark (see #2-4, #35-36, #45-46).	Due to more precise definitions and DBHDS interventions CSB timeliness rates are showing some improvements, but DBHDS has not yet achieved the 86% metric. Six of 40 CSBs continued to report referral timeliness below this compliance indicator's 86% benchmark. However, statewide accountability on providers will be necessary to achieve and to sustain achievement this metric, since it is often the unilateral actions of providers admitting/transferring individuals without notifying case managers that is suppressing the timeliness rate.	17th- NOT MET 19th- NOT MET
20.03	3. DBHDS conducts a quarterly quality assurance review of all new authorizations and any changed authorizations for residential service resulting in individuals residing in homes with 5 beds or more to determine if an RST referral has occurred.	WaMS quality assurance look-behinds surfaced 32 needed referrals, which had not been initiated by the CSBs in FY21, above and beyond the 516 non-emergency referrals (see #2-4, #35-36, #45-46).	DBHDS has complied with this indicator for two review periods	17th- UD 19th- MET

VA #	III.D.6 - RST	Verified Facts	Analysis	Status
20.04	4. DBHDS is in compliance with the agreement when 86% of all statewide situations meeting criteria for referral to the RSTs with respect to home and community-based residential services are referred to the RSTs by the case manager as required by the DBHDS RST Protocol.	DBHDS reported FY21 compliance rates for non-emergency referrals (late primarily due to CSB delays) of: 81%-Q1 88%-Q2 89%-Q3 94%-Q4 This meets the metric of 86% (see #2-4, #35-36, #45).	This improvement over the past year review cycles suggest CSBs are responding to feedback on their RST submission performance; late or non-referrals out of their control are removed from this data (Reason A). Reasons B & C are within provider control, so there should be further constraints on admissions or transfers completed without case manager notification.	17th- NOT MET 19th-MET*
20.05	5. DBHDS reviews all RST submissions for compliance with both the referral and timeliness standards specified in the DBHDS RST Protocol, by CSB. DBHDS will hold CSBs accountable for submitting 86% of their non-emergency referrals timely in accordance with the DBHDS RST Protocol.	DBHDS continues to provide training and technical assistance on RST referral and timeliness requirements (see #5) and sending quarterly RST feedback letters to CSB and annual performance letters from the CMSC (see #15, #26).	DBHDS achieved this indicator during this review period.	17th- NOT MET 19th- MET
20.06	6. DBHDS will require CSBs to submit corrective action plans through the Performance Contract when there is a failure to meet the 86% criteria for 2 consecutive quarters for submitting referrals or timeliness of referrals.	DBHDS informed the CSBs through an annual performance letter (see#26) that a CAP was required if RST referrals were non-compliant. Six CAPs by CSBs that did not meet the 86% criteria were submitted and approved for FY21 (see #20-25); these six CSBs were placed on the DBHDS Watch List for RST performance (see #39).	DBHDS has fulfilled this indicator's requirement during this review cycle. If DBHDS determines that the RST data are reliable and valid and available for compliance reporting, it is possible that adherence to this indicator can be assessed for continued compliance during the next (20th) review period.	17th- NOT MET 19th- MET

VA #	III.D.6 - RST	Verified Facts	Analysis	Status
20.07	7. Failure of a CSB to improve and meet the 86% criteria over a 12- month period following a corrective action plan will lead to technical assistance, remediation, and/or sanctions under the Performance Contract.	DBHDS initiated CAPs pursuant to this indicator in October 2020, so the 12-month period will conclude October 2021. This metric cannot be assessed until 2022 (see #26). DBHDS continues to provide training and technical assistance on RST referrals requirements (see #5).	DBHDS has fulfilled its responsibilities to issue and monitor performance during this review cycle. Whether DBHDS has met this metric cannot be assessed until 2022.	17th- NOT MET 19th- NOT MET
20.08	8. DBHDS will conduct data analyses periodically, but not less than on an annual basis, to ensure that the DBHDS revised RST protocol and referral forms are improving the timeliness of referrals to RSTs.	DBHDS has continued its annual survey of RST members for input, feedback, and recommendations on the referral process (see #30-31). A change to WaMS was made FY18 that began to automate the RST referral and informed choice forms (see#2, #8-9). Full RST incorporation into the automated system, including barriers, is expected FY22 (see #1). Process improvements continued through FY21 (see#2).	DBHDS has fulfilled this expectation on an annual basis for three review cycles.	17th- UD 19th- MET*
20.09	9. DBHDS will ensure the availability of DBHDS Community Resource Consultants to work with case managers to explore community integrated options, including working with providers to attempt to create innovative solutions for individuals with unique or specialized needs, to avoid placements in congregate settings with 5 or more individuals.	CRCs continue to support local case managers in identifying less restrictive and more integrated options for individuals; on occasion these can be innovative (see #6, #40).	DBHDS has maintained and expanded the CRC role and the availability of these services to case managers and providers over two review cycles.	17th -UD 19th-MET

VA #	III.D.6 - RST	Verified Facts	Analysis	Status
20.10	10. DBHDS will incorporate RST data into established Provider Development processes to evaluate gaps in services statewide on a semiannual basis and encourage provider development in underserved areas through information, data, and, if available, provision of funding designated to support provider expansion.	During FY 21 CRCs met with nineteen provider agencies interested in expansion or diversification (see #1). The most recent Provider Data Summary Report (#1) identifies both barriers reported through RST and provider availability by Region. The Jump Start financing program has continued, as well as the development of the Provider Designation Database, regular Provider Roundtables, the Provider Readiness Education Program (PREP), and participation in Charting the LifeCourse. (See #1)	DBHDS has complied with this indicator over two review cycles.	17th -UD 19th-MET*
20.11	11. DBDHS has a process to review and approve as available requests for emergency waiver slots and other funding supports to address emergency situations when alternate options have been exhausted.	DBHDS has revised and updated its Emergency Slot Request process (see #7).	DBHDS has achieved the requirements of this indicator.	17th - UD 19th- MET
20.12	12. DBHDS will add data related to the RST referral process to the Waiver Management Information System (WaMS). Data on RST referrals that were not successfully diverted from congregate settings of 5 or more individuals will be reviewed annually by DBHDS to ensure that integrated options are reviewed and offered annually.	A change to WaMS was made FY18 that began to automate the RST referral and informed choice forms (see#2, #8-9). Full RST incorporation into the automated system, including barriers, is expected Q3 FY22 (#1-2). RST referrals for those not diverted from 5+ settings are tracked, reviewed annually and CSBs are directed to offer more integrated settings annually (see#10-11, #15)	DBHDS is hoping for full incorporation of RST processes into WaMS in 2022; at that time, it will have fully achieved the requirements of this indicator.	17th- NOT MET 19th- NOT MET

VA #	III.D.6 - RST	Verified Facts	Analysis	Status
20.13	13. DBHDS will identify individuals who chose a less integrated residential setting due to the absence of more integrated options in the desired locality. The names of these individuals will be included in quarterly letters provided to each CSB. On a semi-annual basis, information about new service providers will be provided to CSBs, so that the identified individuals can be made aware of new, more integrated options as they become available A Community Resource Consultant will contact each of these CSBs at least annually to ensure that any new more integrated options have been offered. DBHDS will report annually the number of people who moved to more integrated settings.	DBHDS notifies CSBs quarterly of individuals who accepted less integrated settings in the absence of more integrated settings (see#10-11, #15). DBHDS reports that there is no distinct notification to CSBs of the availability of new service providers; DBHDS advises that it has informed the CSBs that this information is continuously available through two search tools (see #41-42). DBHDS reports that it plans to make this annual CRC notification in December 2021, but CSBs are updated quarterly on these individuals. DBHDS will report the annual number in its FY 21 Q4 RST report, which is expected to be issued by the end of CY 2021.	DBHDS has fulfilled the requirements of this indicator in the past two review cycles	17th UD 19th-MET*

III.E.1-3: Previously reviewed SA Sections.				
VA #		Facts	Analysis	Status
NA	III.E.1 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,	DBHDS continues to fulfill the functions required by this indicator. It has in fact increased resources to the community regional	Based on a review of DBHDS and interviews, DBHDS has continued to sustain its compliance that has been observed over two review cycles.	Sustained Compliance

III.E.1-3: Previously reviewed SA Sections.				
VA #		Facts	Analysis	Status
	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.	consultant effort (see #40). There are 15 staff positions now assigned to Provider Development for regional oversight and guidance.		
NA	III.E.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.	DBHDS continues to comply with this indicator and has in fact increase resources to the community regional consultant effort (see #40). Examples of CRC effort from each region were reviewed; they demonstrate CRCs fulfilling these roles per indicator expectations (see #6)	Based on a review of DBHDS and interviews, DBHDS has continued to sustain its compliance that has been observed over two review cycles.	Sustained Compliance
NA	III.E.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.	DBHDS continues to comply with this indicator as to community regional consultant effort. Review of RST referrals demonstrate CRCs are fulfilling these roles per indicator expectations (see #10)	Sustained compliance has been observed over two review cycles	Sustained Compliance

V.D.2-3: Valid and Reliable Data (applied to the above indicators)				
VA#	Indicator or Provision	Facts		Status
36.01	DBHDS develops a Data Quality Monitoring Plan to ensure that it is collecting and analyzing consistent reliable data. Under the Data Quality Monitoring Plan, DBHDS assesses data quality, including the validity and reliability of data and makes recommendations to the Commissioner on how data quality issues may be remediated. Data sources will not be used for compliance reporting until they have been found to be valid and reliable. This evaluation occurs at least annually and includes a review of, at a minimum, data validation processes, data origination, and data uniqueness.	DBHDS has developed a Data Quality Monitoring Plan (see #29) that assesses validity and reliability of RST data. DQV completed the required annual assessments occurred in mid-year 2019 and 2020, including data origination, data validation and data uniqueness (see #33-34). To improve reliability of the RST data, DBHDS plans to transition from a largely manual effort to automate the referral process in the WaMS.	DQV identified RST data quality concerns in its May 2020 assessment. Documentation was not provided that DQV has assessed the RST data source in 2021 and found that its data quality issues had been remedied (i.e., "manual processes around data cleaning and reporting") and that it provides reliable and valid data for compliance reporting.	NOT MET for the RST data source
36.05	Each KPA contains the following: a. Baseline or benchmark as available. b. The target that represents where the results should fall at or above. c. The date by which the target will be met. d. Definition of terms included in the PMI and a description of the population. e. Data sources (the origins for both the numerator and denominator). f. Calculation (clear formulas for calculating the PMI, utilizing a numerator and denominator). g. Methodology for collecting reliable data (a complete and thorough description of the specific steps used to supply the numerator and denominator for calculation) h. The subject matter expert (SME) assigned to report and enter data for each PMI. i. A Yes/No indicator to show whether the PMI can provide regional breakdown.	DBHDS has established Measure Language (see #32, #47) for two RST metrics used by KPA workgroups (CMSC). These Measures include: a. Baseline, b. The goal or target, c. Definition of terms included in the PMI and a description of the population. d. Data sources. e. clear formulas for calculating the PMI, f. Methodology for collecting reliable data, g. The subject matter expert/Steward), h. "Yes" to show whether the PMI can provide regional breakdowns.	DBHDS has developed the KPA which contains the required elements of this indicator. Although target dates are not specifically stated, it is presumed that all are expected to be achieved by the next reporting period.	MET for the RST data source

37.07	The Office of Data Quality and Visualization will assess data quality and inform the committee and workgroups regarding the validity and reliability of the data sources used in accordance with V.D,2 indicators 1 and 5.	ODQV has assessed RST data quality and informed relevant committees and workgroups (see #33-34) of data quality concerns.	DBHDS has completed the required assessments and informed the workgroups during 2019 and 2020. Note: "Data sources not being used for compliance reporting until they have been found to be valid and reliable." Is addressed at 36.01 above.	MET for the RST data source

**Note*: Since the DBHDS Office of Data Quality and Visualization assessment has not found that the RST data sources provides reliable and valid information for compliance reporting, "*Met" determinations are not yet final, but rather for illustrative purposes only.

Recommendations.

1. DBHDS should consider re-educating the provider community regarding RST process requirements and then providing consequences for provider admissions or transfers without advance case manager notification, e.g., one-month billing claw-back when advance notification of the case manager is not documented.

Attachment 1
Documents Reviewed
RST – Title or BOX Filename

29. 20.0_Provider Data Summary Report May 2021 final 8.4.21
30. 20.01_20.02_DOJ-FY21_3rd_Qtr_RST Report_5.2021
31. 20.03-04 FY21 3rd QTR WaMS Report_T2663_56.3.21
32. 20.03-04 RST_WB_v2_3.1.21 (10)
33. 20.05 - CRC TA Summary April 21
34. 20.09 - Examples of Support
35. 20.11 - Emergency Slot Request Process_1.29.21 final
36. 20.12 - RST Referral Steps for WaMS 6.7.21 final for review
37. 20.12 - VIC Steps for WaMS 6.7.21
38. 20.12 - RST Referrals 1.1.2020-630.2020_7.14.21 (4)
39. 20.12 - RST Less Integrated Referrals 7.1.2019_12.31.2019
40. 20.12 - RST data lookup %2471output 2.11.21
41. 20.12 - RequestTR2442_ISPs_simple_lookup_4 (7.23.21)
42. 20.12 - EXAMPLE LANGUAGE Page 2 – RST Compliance Report_Valley_FY21_3rdQtr
43. 20.13 - RST Compliance Report (40 CSB's) _3rd Qtr.
44. 20.6 - 6.1_Chesterfield RST Reporting Example 2.26.21)
45. 20.6 - 6.1_Chesterfield RST Tracking Example 2.26.21
46. 20.6 - 6.1_Chesterfield Amy Loving PDQ 2.26.21
47. 20.6 - Blue Ridge CMSC Performance Letter FY20 10.21.20
48. 20.6 - BRBH RST CAP 12.2020 revised (received 2.9.21)
49. 20.6 - RST CAP Chesterfield Dec 2020
50. 20.6 – DPCS CAP RST Referrals 4.30.21
51. 20.6 – HAMHDS Corrective Action Plan for SCQR Retrospective Review…..2.9.21
52. 20.6 – HNN CAP 5.28.21
53. 20.6 - RST CAP Region Ten 12-15-2020
54. 20.7 - CMSC Performance Letter FY21 4.30.21final (40 CSBs)
55. 20.8 - RST 2021 Survey Summary Data_All_210830
56. 20.8 - RST 2021 Survey Responses_All_210830
57. 36.01 - DRAFT Case Management Data Quality Reviews Operational Process (8.3.21 - CZ202108209 working draft)
58. 36.01 - CCS3 CSB Survey Individual Responses_All_210901
59. 36.01 - CCSB CSB Summary per question Data_All_210901
60. 36.05 - PMI_RST timeliness of 5 beds or more referrals; PMI_RST non-emergency referrals are in sufficient time for RSTs
61. 37.07 - DQP Phase3_RST
62. 37.07 - DQP Phase1_RST
63. DOJ-FY21_1st_Qtr_RST Report_1.2021 (final) (1)
64. DOJ-FY21_2nd_Qtr_RST Report_3.2021_final (1)
65. 4th Quarter CMSC Report to the QIC June 28, 2021

66. CMSC Report FY 21 1st and 2nd Qrt_3.22.21 final (updated 5.3.21 PPS 13 RST_16-17
67. 20.07 – CMSC Recommendation Letter 8.2.21
68. crc-contacts-by-capacity-area-effective-4.1.21-final-copy.pdf (virginia.gov)
69. http://www.dbhds.virginia.gov/quality-management/Licensed-Provider-Location-Search
70. http://www.mylifemycommunityvirginia.org/
71. 20.13 - RST data lookup T2471 [CY20]
72. 20.13 - RequestTT2442_ISPs_simple
73. CSB Late Chart_RST Data FY21_Q4_10.7.21
74. CM Report 4Q Regional Support Teams final RST Data Results, 9.16.20
75. 4th QTR Case Management Steering Committee Report to the QIC, 6.28.21

Attachment 2
Interviews

Name	Title	Date
Eric Williams	Director, Provider Development, DDS	10.14.21
Jenni Schodt	Settlement Agreement Director, DBHDS	10.14.21
Ashley Painter	Statewide RST Coordinator, DDS	10.14.21

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APPENDIX E

OFFICE OF LICENSING/OFFICE OF HUMAN RIGHTS

By

Ric Zaharia Ph.D.

Consortium on Innovative Practices

Period 19 – Compliance Indicators: Office of Licensing/Office of Human Rights

Ric Zaharia, Ph.D.

November 5, 2021

Executive Summary

The Office of Licensing (OL) and the Office of Human Rights (OHR) continue to function competently. OL sustained its heightened rate of utilizing provisional licensing designations for underperforming agencies and completed its second year of its licensing process including the Adequacy of Supports assessments. OHR cross-tabbed Adult Protective Services/Child Protective Services (APS/CPS) reports with CHRIS incident reports, in a similar fashion to the Department's cross-tabulation with medical claims and CHRIS incident reports for emergency hospitalization. Timely incident reporting rates have maintained above the indicator benchmark of 86%. Although there is no similar indicator benchmark for Adequacy of Supports, DBHDS trend reporting has established a baseline above 86% across the eight domains. This latter reporting, i.e. identifying domains that are not adequately addressed, should become increasingly helpful in shaping system improvement initiatives.

Introduction

Beginning in March 2020 through March of 2021 COVID restrictions under the Governor's Executive guidelines altered all face-to-face onsite visits to providers. On-site inspections were gradually reinstituted beginning April 1, 2021. The inability to do on-site inspections undermined DBHDS ability to show compliance in the 17th Period Review.

Prior to the March 2020 introduction of the Adequacy of Supports checklist, 100+ OL regulations relevant to IDD were not prioritized, so the local Licensing Specialist focused equally on all regulations. The OL assessment of Adequacy of Supports (AOS) checklist, which was launched in March 2020 focused Licensing Specialists on 27 key and 44 reference regulations that reflect the themes of the seven AOS domains. All 100+ regulations are available for citation, but these 27 regulations must be specifically assessed. OL Supervisors review Licensing Specialists' inspection reports to ensure the key Adequacy of Support regulations are addressed.

OL analyzes the Adequacy of Supports into two areas – Private Provider and Case Management. Private Providers have primary regulatory responsibility for two of seven domains: Choice & Self-determination and Safety & Freedom from Harm. Case Management has primary regulatory responsibility for five domains: Access to Services, Avoiding Crises, Community Inclusion, Physical-mental-behavioral health & Well-being, and Provider Capacity. During the 17th Period Study, DBHDS projected that it would be informed of its status fulfilling the responsibilities of the eighth domain, Stability, by data points other than regulations.

The 17th Period review also identified the positive impacts of several years of DBHDS investments in OL. The cumulative impact of developing a) a OL Regional Manager's role, b) an OL Incident Management Unit, c. the Special Investigations Unit and d) the OL and OHR Incident Look Behind Process, provide assurances of improved system oversight. In his 17th Report to the Court the Independent Reviewer determined that the Commonwealth had Met three (i.e. 34.02, 34.03 and 34.07)) of the eight compliance indicators for V.C.6. and one (i.e. 48.03) of the four indicators for V.G.3. The Commonwealth had Not Met the V.D.3 compliance indicator 37.07 for determining that data from the Office of Licensing could be submitted for compliance reporting.

19th Review Period Overview

The 19th Period study found that DBHDS's OL and OHR implemented and refined its systems and met several compliance indicators that it had not previously achieved.

DBHDS reported for FY20 that serious incidents were submitted at a timeliness rate of 89.6%. FY21 reporting indicates these annual rates have improved to 92%. These percentages, however, did not include the late- reporting found in medical claims data. Adjustment analysis DBHDS conducted and provided to the author states that timeliness percentages need a 2% negative adjustment to account for unreported hospitalizations.

DBHDS/DMAS's first round in FY20 of cross-tabbing medical claims for emergency hospitalizations with CHRIS incident reports for the 17th period review identified that up to 10% were not reported and 90% reported. For this 19th Period review, DBHDS determined that up to 16% were not reported and 84% were reported. The increase in the percentage of incidents that may not have been reported as required may be due to DBHDS accelerating its analysis for this report and concluding with a large number of reports (177) that were undetermined as to validity; as a result the mathematical analysis treated these as unreported incidents until additional research could be conducted to determine their validity.

In addition, during this period OHR cross-tabbed APS/CPS reports with CHRIS incident reports, which is a very positive initiative, as it will help identify additional gaps in the required reporting of critical incidents. These unreported incidents have been included in the DBHDS quarterly reporting percentages. This cross-tabbing did not occur in the 17th review period.

OL reported that for FY 21 (Q4), it had followed up on 95% of providers that were required to complete CAPs when cited for failing to report. Documentation reviewed showed that OL followed up appropriately (i.e., ensure that CAPs have been implemented within 45 and/or 90 days) and took action when providers fail to correct.

In the 17th Review Period, the OL checklist for assessing Adequacy of Supports included seven of the eight areas. In this review Stability, the eighth domain, has been added to the OL analysis using crisis service data points. In the last review the OL checklist was applied remotely during the annual visit cycle and was evaluated primarily on the availability of documentation from the provider. Remote data collection by OL concluded this past spring with the reinstitution of on-site inspections in April 2021.

In the last review OL's use of provisional status for underperforming providers was at a high rate which this review determined that OL had sustained over the past year. Again, as previously reported provisional status is the primary negative consequence used by OL following the failure of agencies to successfully implement corrective action plans.

DBHDS has chartered three KPA workgroups centered on the AOS framework. (See # 84-86). OL/OHR support the *Health, Safety, and Wellbeing Workgroup*. Measurement language has been established for timeliness and CAP follow-up (see #59, #80). OL has generated the measurement dimension tied to the construct of Adequacy of Supports (see #76)

The 19th Period study determined the Commonwealth has Met eleven of the twelve compliance indicators reviewed for the OL/OHR provisions V.C.6 (34.01-.08), and V.G.3 (48.01-48.04), compared with having Met four during the 17th Period's review.

Methodology

For this Period, I reviewed over 90 documents (Attachment 1) that DBHDS felt showed evidence of their compliance with the indicators I also interviewed three DBHDS staff (Attachment 2) and exchanged clarifying emails when warranted.

To determine whether the Adequacy of Supports "checklist" was adequate, this study included the review of the Licensing Specialists' citation report that references the applicable DBHDS regulation(s) and the Licensing Specialist narrative, and, if applicable, the request for a CAP. Copies of the Licensing Specialist working drafts were not available because the Office of Licensing reported that its process converts the digitized checklist completed by the Licensing Specialist directly into the reports that were provided for review.

Prior to initiating its Adequacy of Supports "checklist", the DBHDS licensure process had broadly assessed whether providers were in compliance with each of the 100+ DBHDS licensing regulations. The AOS checklist is a digitized version of the 27 key regulations that reflect the themes of seven AOS domains. The compilation of the licensing process findings related to these 27 regulations is the DBHDS assessment of adequacy. The OL electronic worksheet is applied by the Licensing Specialist to all settings as appropriate and is reviewed by supervisors as to content and completion of the elements of the "checklist". This review examined a sample of eight inspections with CAPS from the review period to confirm that the Adequacy of Supports assessment framework is consistently applied.

Compliance Indicator Tables

V.C.6 – OL/OHR – Failure to report				
VA#	Indicator or Provision	Facts	Analysis	Status
34.01	1. DBHDS identifies providers, including CSBs, that have failed to report serious incidents, deaths, or allegations of abuse or neglect as required by the Licensing Regulations. Identification occurs through a. Licensing inspections and investigations b. DBHDS receipt of information from external agencies, such as the protection and advocacy agency, or other agencies such as the Department of Health or local adult protective services agencies. c. Any other information that DBHDS may receive from individuals, other providers, family members, or others d. Reports of deaths from the Virginia Department of Health as described in Indicator 7.c of V.C.5	OL identifies and tracks failure to report incidents by provider agency as they are identified (see #81) through inspections, investigations, or other sources such as complaints or care concerns. This includes monthly VDH reports of death of waiver users (see #88-89). OL tracks all complaints and incident reports that are health and safety issues (serious injury, death, allegations of abuse or neglect) through a centralized Incident Management Unit (see #1-4, #8, #15). This Unit maintains a spreadsheet of late reports, which is informed by daily data pulls of the CHRIS system; unexcused late reports trigger the citation/CAP request process by the unit. Documents reviewed and interviews conducted verified that OHR specifically tracks APS/CPS	This review verified that DBHDS has sustained the increased resources assigned, and that OL and OHR have maintained the structures and operational protocols which led to their previous and more recent achievement of the applicable compliance indicators. By maintaining the resources, structures and operations DBHDS has demonstrated that OL and OHR have provided a high level of scrutiny and prioritization for negative events during the past two review cycles.	17th *NOT MET* 19th *MET*

V.C.6 – OL/OHR – Failure to report				
VA#	Indicator or Provision	Facts	Analysis	Status
		reports (see #11- 14), OL citations (see #8), and follow-up. OHR tracking has revealed that in Q2-3 FY21 providers failed to timely report 96 incidents out of 296 APS/CPS reports (32%). Follow-up included citations/ CAPs as appropriate to the respective providers (#14). DBHDS states these late reports are included in the larger number of late report figures at 34.04		
34.02	2. To validate that medical-related incidents are reported as required, at least annually, the Commonwealth conducts a review of Medicaid claims data and how it correlates to serious incidents reported to DBHDS. This review will be done of individuals enrolled in the DD waivers who receive one of the following waiver services: group home residential, sponsored residential, and supported living. Data related to Medicaid claims screened includes services associated with reporting requirements for: i. emergency room visits; and ii. hospitalizations	DMAS and DBHDS has again matched medical claims data (ER and hospital visits) for the identified individuals with corresponding incident report data for Q1 FY21 (see #16-17).	DBHDS accomplished this requirement in FY20 (17th period) and again in FY21 (19th period).	17th *MET* 19th *MET*
34.03	3. One quarter of data related to Medicaid claims is reviewed per calendar year for each of the following DD waivers under the direction of DBHDS: i. Building Independence, ii. Community Living, iii. Family and Individual Supports	The Q1 FY21 review resulted in 1614 distinct visits for 989 individuals; Of these visits (i.e. emergency room and hospitalizations) 960 (60%) matched to a DBHDS incident report. DBHDS tracked down the 654 visits that were not matched to an incident report (see#17, #71). DBHDS determined that 388 of these claims were excused (incident report located or reporting	DBHDS analysis indicates that, when the total number of timely + untimely incidents was adjusted (10,019= 226+9753) the overall late report rate for FY21 dropped 2% (see #71). It is possible that many of the 177 unvalidated claims included as unreported could be excused, resulting in a percentage unreported	17th *MET* 19th *MET*

V.C.6 – OL/OHR – Failure to report				
VA#	Indicator or Provision	Facts	Analysis	Status
		criteria were not met). For the remaining 266 missing reports DBHDS was able to validate 89 unreported incidents but could not conclude the validity of 177 claims; these 177 were treated as unreported for the sake of analysis. DBHDS notified these providers of the discrepancy, reminded them of the reporting requirements, and directed them to have staff re-take training on IR reporting; failure to do so will result in a citation/CAP. The largest share of the 989 individuals were in the Community Living waiver. Only four were in the BI or FIS waiver.	closer to the 17th period. DBHDS accomplished this task in FY20 and in FY21.	
34.04	4. At least 86% of reportable serious incidents are reported within the timelines set out by DBHDS policy.	OL reporting is that timeliness in FY21 was: Q1 – 87% Q2 – 93% Q3 – 94% Q4 – 95% For FY21 there were 8996 timely reports against 9,753 total reports (92%). These rates are adjusted for missing APS/CPS reports but not hospitalizations (see 34.03 above)	After DBHDS includes the missing APS/CPS reports into its percentages of reported incidents and when the hospitalizations are included the percentages of reported incidents will still achieve the metric of 86% over two review cycles (89.6% FY20 (see #70) and 90% in FY21. DBHDS has not yet determined that OLS data is reliable and	17th *NOT MET* 19th *MET**

V.C.6 – OL/OHR – Failure to report				
VA#	Indicator or Provision	Facts	Analysis	Status
			valid for compliance reporting	
34.05	5. Providers, including CSBs, that fail to report serious incidents, deaths, or allegations of abuse or neglect as required by the Licensing Regulations receive citations and are required to develop and implement DBHDS-approved corrective action plans.	OHR & OL track late reporting (see #8, #18) and generate CAPs as appropriate, e.g., in Q4 FY21 OL issued 97 citations for late reports and requested CAPs from 92 (95%) agencies (see #18 – some late reports are appropriately excused for cases where CHRIS system is down, power outages, etc.).	DBHDS has historically cited agencies for late reporting, but began systematically citing agencies for late reports pursuant to a defined process in October of 2020 (see #4), so this is the first review with an opportunity to verify that the new process meets this requirement and that it was implemented. However, since non-health and safety CAP implementation is not verified until the next annual inspection, CAP implementation could not be verified in this cycle.	17th *NOT MET* 19th *NOT MET*
34.06	6. DBHDS reviews and approves corrective action plans that are in response to serious incidents, abuse, neglect, or death in accordance with the Licensing and Human Rights Regulations. DBHDS follows-up on approved corrective action plans to ensure that they have been implemented and **are achieving their intended outcomes** as follows: a. For serious injuries and deaths that result from substantiated abuse, neglect, or health and safety violations, the Office of Licensing verifies that corrective action plans have been implemented within 45 days of their start date. b. In cases of substantiated abuse or neglect that do not involve serious injury or death, the Office of Human Rights verifies that corrective action plans have been implemented within 90 days of their start date. c. On an annual basis, at least 86% of corrective action plans related to substantiated abuse or neglect, serious incidents, or deaths are fully implemented as specified in this indicator or, if not implemented as specified, DBHDS takes	6. OHR managers triage incident reports for abuse, neglect, etc. by reviewing all incoming CHRIS reports, generating 11 data warehouse reports 3x weekly (see #6). OL managers review and approve CAPs resulting from ensuing inspections, incidents, or complaints (see #4, #8, #43) a. OHR and OL track CAPs for follow-up	DBHDS tracks corrective action plans with substantial documentation and has achieved the 86% benchmark over two review cycles.	17th *NOT MET* 19th MET*

V.C.6 – OL/OHR – Failure to report				
VA#	Indicator or Provision	Facts	Analysis	Status
	appropriate action as determined by the Commissioner in accordance with the Licensing Regulations.	(see #9, #20, #43); e.g., 27 IDD providers had CAPs closed in Q3-4FY21 for death or serious injury; 24 (89%) had their CAPs closed within 90 days (see#5, #43). In this study, a sample of 8 CAPs was reviewed and their documents evaluated; (see #5); two were tied to annual inspections, six were tied to a complaint or incident; five citations were corrected with one CAP, two were corrected with two CAPs, and the eighth was addressed with three CAPs and the provider's license was downgraded to "provisional". OL during the past 12 months has placed 7 agencies on provisional licensed status; 2 of these agencies subsequently closed or surrendered their licenses (see #44). b. OHR tracking in Q3-4FY21 indicates that for 231 reported allegations of abuse, neglect, or death, 230 incidents were closed within 90 days	The documentation for the CAPs reviewed is sufficient to ensure providers are receiving citations, corresponding corrective action plans, and needed follow-up. As previously reported DBHDS appears hesitant to use all enforcement tools for underperforming agencies.	

V.C.6 – OL/OHR – Failure to report				
VA#	Indicator or Provision	Facts	Analysis	Status
		(99.5%). (See #19) OHR tracks all substantiated cases (see#65). OL tracks and verifies implementation of needed corrections of health and safety citations within 45 days as required. OL checks the providers' status regarding non-health & safety requirements CAPs (e.g., missing ISP signatures) during the next annual inspection (see #20, #8). However, Licensing Specialists have the discretion to follow-up sooner on CAPs provided for citations that are not death or serious injury. c. In Q3-4FY21 IDD providers had 27 CAPs closed for death or serious injury - 24 (89%) had their CAPs closed within 90 days; three CAPs were not satisfactorily implemented within 90 days; a second CAP was required of two providers and satisfactorily closed within an additional 30 days; one provider was referred to OL management for negative action.		

V.C.6 – OL/OHR – Failure to report				
VA#	Indicator or Provision	Facts	Analysis	Status
		DBHDS downgraded this provider's license for 6-months to provisional status (see#5, #43).		
34.07	7. Providers, including CSBs, that have recurring deficiencies in the timely implementation of DBHDS-approved corrective action plans related to the reporting of serious incidents, deaths, or allegations of abuse or neglect will be subject to further action as appropriate under the Licensing Regulations and approved by the DBHDS Commissioner.	DBHDS has documented taking further actions as appropriate (e.g., agencies reporting late 3 or more times in a period are required to re-take mandatory incident report training – see #21). Overall, in Q4 FY21, the first half of the 19th review period, OL issued 97 citations for late reports and requested CAPs for 92 (95%). (See #18).	DBHD has sustained increased utilization of downgrading providers' licenses to provisional status, which is sufficient evidence that DBHDS continues to take further action as appropriate. DBHDS continues to appear hesitant to use all its enforcement tools for outlier agencies. (See recommendations)	17th *MET* 19th *MET*
34.08	8. DBHDS has Policies or Departmental Instructions that specify requirements for Training Centers to report serious incidents, including, deaths, or allegations of abuse or neglect and to implement and monitor corrective actions. a. DBHDS has a process to monitor the implementation of corrective actions. b. When DBHDS identifies that harms have not been reported in accordance with policies or Departmental Instructions, an analysis is conducted to identify root causes; DBHDS implements corrective action as necessary to address identified causes.	This review verified that DBHDS has policies that specify requirements for TC reporting and implementing CAPs (see #6, #8, #20, #27, #28, #31, #63, #64, #72). a. OHR has a process in place and conducted a look-behind of SEVTC serious incidents Q3 FY21, which included monitoring the implementation of any corrective action plans	DBHDS has complied with these requirements for the past two review cycles.	17th *NOT MET* 19th *MET**

V.C.6 – OL/OHR – Failure to report				
VA#	Indicator or Provision	Facts	Analysis	Status
		(see #22). SEVTC was also included in the cross-tab of APS/CPS reports (none identified – see #90) b. DBHDS reports that all incidents during FY21 have been reported per policy (see #73-75). RMRC reviewed two corrective actions for abuse in CY21 (see #69). The RMRC also reviews serious incidents at SEVTC (see#75) and ensures corrective actions are implemented and that root causes are assessed. Evidence of root cause analysis at SEVTC was provided (see #75, #91-93).		

V.D.3- Ensuring Reliable Data				
VA#	Indicator or Provision	Facts	Analysis	Status
37.07	The Office of Data Quality and Visualization will assess data quality and inform the committee and workgroups regarding the validity and reliability of the data sources used in accordance with V.D,2 indicators 1 and 5.	OQDV has summarized its assessment of OL/OHR data quality (see #78-79) and informed committees and workgroups regarding the validity and reliability of data sources. An analysis of threats to reliability/validity in	An OL/OHR specific assessment is not documented or detailed.	17th *NOT MET* 19th *NOT MET*

		the OLIS and CHRIS systems are planned for later in FY22 (see #78).		

V.G.1 and V.G.2				
VA#	Indicator or Provision	Facts	Analysis	Status
NA	*Settlement Agreement* *V.G.1 "The Commonwealth shall conduct regular, unannounced licensing inspections of community providers serving individuals receiving services under this Agreement.*	DBHDS resumed its schedule of on-site unannounced inspections 4.1.21 (see #58, #66-68).	This review verified that DBHDS has sustained its efforts in this area.	17th *Sustained Compliance* 19th *Sustained Compliance*
NA	*V.G.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 behavioral or medical 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 multiple less serious crises within a three month period;* *e. Provides 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.*	DBHDS resumed its more frequent inspections based on these six criteria 4.1.21 (see #58, #66-68).	DBHDS has sustained its efforts in this area.	17th *Sustained Compliance* 19th *Sustained Compliance*

V.G.3 – OL - Adequacy of Supports (AOS)				
VA#	Indicator or Provision	Facts	Analysis	Status
48.01	1. The DBHDS Office of Licensing (OL) develops a checklist to assess the adequacy of individualized supports and services (including supports and services for individuals with intensive medical and behavioral needs) in each of the domains listed in Section V.D.3 for which it has corresponding regulations. Data from this checklist will be augmented at least annually by	OL implemented a revised inspection process in early 2020. This review verified that the new process was based on seven AOS domains and a regulatory checklist. The	OL has developed an Adequacy of Supports checklist that includes 27 regulations. These regulations address seven of the eight domains listed in V.D.3 and relate to supports	17th *NOT MET* 19th *MET*

V.G.3 – OL - Adequacy of Supports (AOS)				
VA#	Indicator or Provision	Facts	Analysis	Status
	data from other sources that assess the adequacy of individual supports and services in those domains not covered by the OL checklist.	OL electronic checklist is applied to all settings as appropriate and includes those with intensive medical and behavioral needs. (See #37-38, #54) Crisis service data is now utilized to inform the eighth domain of Stability: the number of individuals discharged from their residential provider following a REACH call or contact (see #49-51).	and services for individuals with complex needs. Data for the eighth domain, Stability, which is not covered by the OL checklist has been provided from crisis services and was reviewed for FY20.	
48.02	2. The DBHDS Office of Licensing uses the checklist during all annual unannounced inspections of DBHDS-licensed DD service providers, and relevant items on the checklist are reviewed during investigations as appropriate. Reviews are conducted for providers at least annually pursuant to 12VAC35-105-70	This review verified that DBHDS licensed providers receive annual, unannounced inspections based on the AOS checklist (see #37-38, #54). Relevant regulations are also cited on incident specific investigations (see #4-5); however, those are more likely to be citations outside the AOS framework due to the idiosyncratic and procedural nature of negative event investigations (e.g., signed progress notes).	DBHDS has implemented and maintained the use of the checklist over two review cycles.	17th *NOT MET* 19th *MET*
48.03	3. DBHDS informs providers of how it assesses the adequacy of individualized supports and services by posting information on the review tool and how it is assessed on the DBHDS website or in guidance to providers. DBHDS has informed CSBs and providers of its expectations regarding	OL informed providers of the AOS inspection process at its introduction in March 2020 (see #82-83) and has provided subsequent	DBHDS has implemented and provided subsequent updates over two review cycles.	17th *MET* 19th *MET*

V.G.3 – OL - Adequacy of Supports (AOS)				
VA#	Indicator or Provision	Facts	Analysis	Status
	individualized supports and services, as well as the sources of data that it utilizes to capture this information.	updates (see #76, #87). Although DBHDS has the capability to complete roll-up AOS reports for an agency/site, it does not do so.	OL perceives no value in rollup AOS reports at the agency/site level. Given the feedback to providers in the citation-CAP process, this review supports their argument. Similarly, rollups at the individual level appear unnecessary because the citation-CAP process requires the citation be specific to an individual and the correction of the specific deficiency related to the individual, as well as others similarly affected (See #4, #37-38, #68).	
48.04	4. The DBHDS Office of Licensing produces a summary report from the data obtained from the checklist. On a semi-annual basis, this data is shared with the Case Management Steering Committee and relevant Key Performance Area workgroups. These groups evaluate the licensure data along with other data sources, including those referred to in indicator #1, to determine whether quality improvement initiatives are needed. A trend report also will be produced annually for review by the QIC to ensure that any deficiencies are addressed. If improvement initiatives are needed, they will be recommended, approved, and implemented in accordance with indicators 4-6 of V.D.2.	DBHDS completed two semi-annual reports and produced an annual report was produced for CY 20 (see #49-51). These were shared with the CMSC and QIC. The most recent annual report identified trends for CY20. This report (#50) is directed to QIC and is in the form of a 6 page memorandum. The QIC and CMSC have reviewed the semi-annual AOS reports. A decision regarding improvements is waiting for further monitoring information (see #49-51, #69) before finalizing	DBHDS did not achieve this Indicator during the 17th period because its annual inspections were not unannounced, on-site or in-person. DBHDS reduced the COVID precautions, and such visits occurred during the 19th Review Period	17th *NOT MET* 19th MET*

V.G.3 – OL - Adequacy of Supports (AOS)				
VA#	Indicator or Provision	Facts	Analysis	Status
		recommendations for improvement.		

*The Independent Reviewer has not been provided documentation that DBHDS has determined that the Office of Licensing data source provides reliable and valid information for compliance reporting. Therefore, "*met" determinations are not yet final, but rather for illustrative purposes

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Recommendations:

1. DBHDS should consider constructing a protocol for corrective actions with underperforming agencies, including timelines and clear negative events for repeated failures to improve sufficiently to meet regulatory requirements.

Attachment 1
Documents Reviewed

OL/OHR – Title or BOX Filename

76. 34.01_05.2021 Complaint Protocol
77. 34.01_FINAL 160 Protocol for DD providers
78. 34.01 2021 Licensing Complaints Protocol
79. 34.01 Office of Licensing Protocol for Assessing Serious Incident Reporting by Providers of Developmental Services
80. 34.05- Health & Safety Citations/CAPs-8 (Failure to Report)
81. 34.1_34.6bProtocol No 313 OHR Triage Process
82. 34.1_34.5_Provider Late Reporting due to Education 2.10.20
83. 34.1_34.5_Protocol No 317 OHR and OL (IMU)
84. 34.1_34.6_Protocol No 309 A.I.M.
85. 34.1_34.5_AA Provider Late Reporting
86. 34.1_Protocol No 312 APS_CPS Report Tracking
87. 34.1_DBHDS APS and CPS Protocol 7 25 17 final
88. 34.1_APS-CPS Report Tracker Tableau Data Points
89. 34.1_Dashboard_APSTracker Q2_Q3FY21
90. 34.1-19th Study-August 31, 2021
91. 34.2_34.3_DMAS-CHRIS_match_PHI
92. 34.2_34.2_DMAS_CHRIS_Analysis 2021
93. 34.5 Citations
94. 34.6b_DW-0071-OHR90Days Q2_Q3FY21
95. 34.6b_34.6b_OHR CAP Protocol 148 8.1.21
96. 34.7 -3rd citation training log-19th Study
97. 34.8_SEVTC Report FY21_Report to RMRC_Aug2021
98. 34.8_Facility Advocate EWP – highlighted for DOJ 34.8
99. 34.8_Copy of Monthly Comm Report through July 2021
100. 34.8_FLB Reviews Timeline
101. 34.8_Facility form technical notes for 2021 cases
102. 34.8O_Facility Violation Letter Memo 1.7.21
103. 34.8_DI 201 Abuse and Neglect 2018 01 18 REVISED withCmsrMemo
104. 34.8_RMRC Q3 FY21 FLB Report Sept 2021
105. 34.8_FLB_main_spreadsheet_CY2021 SEVTC
106. 34.8_Protocol 145 Violation Notice – Revised 12-15-20
107. 34.8_SEVTC OHR Violation Letter Tracking
108. 36.4, 36.5, 37.1, 37.5, 37.7 Corrective actions for substantiated ANE are implemented Last Updated 2.24.21
109. 36.4, 36.5, 37., 37.5, 37.7 Regulatory requirements of QI programs Updated 8.12.21
110. 36.4, 36.5, 37.1, 37.5, 37.7 Regulatory requirements of RM programs 8.12.21
111. 36.4, 36.5, 37.1, 37.5, 37.7 Risk Incident Monitoring Rates Last Updated 7.22.21
112. 48.01 - Key Regulatory Compliance Checklist Adequacy of Supports_5.15.20

113. 48.01 – OL annual checklist compliance determination chart-FY2021
114. 48.02 – 3 Citation/CAPs (Adequacy of Supports)
115. 48.03_starts page 12_01.2020 Director Updates
116. 48.03_starts slide 21_october-2020-sa-stakeholder-slides_adequacy of supports_10.30.20
117. Adequacy of Support semi-annual cover letter
118. OL Health & Safety_Ric_19th (tracking spreadsheet)
119. Tracking Spreadsheet for Enforcement and Negative Actions
120. Incident reporting –OL
121. Guidance-for-serious-incident-reporting
122. Incident Reporting Guidance
123. Chris_system_training_mayo-2021-final
124. 3rd semi-annual report (1.1.21 to 6.30.21)
125. 1st annual trend report (1.1.20 to 12.31.20)
126. 2nd semi-annual report 7.1.20 to 12.31.20)
127. Annual Trend Report for Adequacy of Supports 1-1-20 to 12-31-20
128. Agenda January 8, 2020
129. The Implementation of the DBHDS licensure process for adequacy of Supports-summary (rationale)
130. DOJ – FY21Q2- Crisis – Supplemental DOJ Quarterly Crisis Report 1.15.2021 DRAFT
131. DOJ – FY21 Q1 – Crisis – Supplemental Crisis Report 10.15.2020 DRAFT
132. DOH – FY21Q3 – Crisis – Supplemental DOJ Quarterly Crisis Report 4.15.21 DRAFT
133. V.G.2_DBHDS Office of Licensing DF Inspection Protocol
134. 36.4, 36.5, 37.1, 37.5, 37.7 Critical incidents a re reported on time Last Updated 2.24.21
135. 36.4, 36.5, 37.1, 37.5, 37.7 Regulatory requirements of RM programs 8.12.21 (1)
136. 36.4, 36.5, 37.1, 37.5, 37.7 Provider investigations of abuse and neglect allegations are conducted Last Updated 6.9.21
137. 36.4, 36.5, 37.1, 37.5, 37.7 State policies and procedures for the use or prohibition of seclusion Last Updated 2.24.21
138. OHR Role in the CAP Process – Protocol No. 316
139. OHR Facility Look-Behind (SEVTC) – Q3 FY21
140. Email, Goldman to Zaharia, 9.13.21
141. Memorandum, Benz-Goldman-Means to Licensed Providers, Return to Field Operations, 3.26.21
142. V.G.1 & V.G.2 Licensing Inspections Provisions
143. http://www.dbhds.virginia.gov/quality-management/Office-of-Licensing
144. Email, Nair to Zaharia, 9.20.21
145. Summary of analysis for V.C.6.4 and for health and safety CAPS.pptx
146. 34.02 Follow-up on Medicaid Claims Review, undated
147. 34.8_DI401 (Departmental Instruction)
148. 34.8_SEVTC Q1 minutes
149. 34.8_SEVTC Report FY21
150. 34.8_RMRC Minutes 8.16.21
151. Adequacy of Supports Q1 9.2021 (powerpoint)

152. Data Quality Monitoring Plan – Annual Update Process, April 2021

153. Data Quality Monitoring Plan – Source System Annual Update, June 2021

154. Data Quality Monitoring Plan – Reassessment with Actionable Recommendations, June 2021

155. Measure Language – Corrective Actions for Substantiated cases of ANE. 2.24.21\

156. DW98SampleDetails, undated.

157. Correspondence to Providers, Benz, 3.14.20

158. Memo to Providers re Remote Inspection Protocol, 5.15.20

159. Health, Safety and Wellbeing Workgroup Charter, FY22, undated

160. Community Inclusion and Integration Workgroup Charter, FY22, undated

161. Provider Capacity and Competency Workgroup Charter, FY22, undated

162. Statewide Provider Roundtable, Webinar, 10.26.21

163. Mortality Review Office/Mortality Review Committee Process and Procedure Document, Undated.

164. Email, Schodt to Zaharia, 11.3.21

165. Email, Goldman to Zaharia, 11.3.21.

166. Email, Nair to Zaharia, 11.4.21

167. Review of Failure/Late Reporting of Abuse/Neglect Allegation, undated, (SEVTC-10.11.21)

168. SEVTC Instruction Number 4060: Policy on Abuse and Neglect, 11.9.20.

Attachment 1
Documents Reviewed

OL/OHR – Title or BOX Filename

169. 34.01_05.2021 Complaint Protocol
170. 34.01_FINAL 160 Protocol for DD providers
171. 34.01 2021 Licensing Complaints Protocol
172. 34.01 Office of Licensing Protocol for Assessing Serious Incident Reporting by Providers of Developmental Services
173. 34.05- Health & Safety Citations/CAPs-8 (Failure to Report)
174. 34.1_34.6bProtocol No 313 OHR Triage Process
175. 34.1_34.5_Provider Late Reporting due to Education 2.10.20
176. 34.1_34.5_Protocol No 317 OHR and OL (IMU)
177. 34.1_34.6_Protocol No 309 A.I.M.
178. 34.1_34.5_AA Provider Late Reporting
179. 34.1_Protocol No 312 APS_CPS Report Tracking
180. 34.1_DBHDS APS and CPS Protocol 7 25 17 final
181. 34.1_APS-CPS Report Tracker Tableau Data Points
182. 34.1_Dashboard_APSTracker Q2_Q3FY21
183. 34.1-19th Study-August 31, 2021
184. 34.2_34.3_DMAS-CHRIS_match_PHI
185. 34.2_34.2_DMAS_CHRIS_Analysis 2021
186. 34.5 Citations
187. 34.6b_DW-0071-OHR90Days Q2_Q3FY21
188. 34.6b_34.6b_OHR CAP Protocol 148 8.1.21
189. 34.7 -3rd citation training log-19th Study
190. 34.8_SEVTC Report FY21_Report to RMRC_Aug2021
191. 34.8_Facility Advocate EWP – highlighted for DOJ 34.8
192. 34.8_Copy of Monthly Comm Report through July 2021
193. 34.8_FLB Reviews Timeline
194. 34.8_Facility form technical notes for 2021 cases
195. 34.8O_Facility Violation Letter Memo 1.7.21
196. 34.8_DI 201 Abuse and Neglect 2018 01 18 REVISED withCmsrMemo
197. 34.8_RMRC Q3 FY21 FLB Report Sept 2021
198. 34.8_FLB_main_spreadsheet_CY2021 SEVTC
199. 34.8_Protocol 145 Violation Notice – Revised 12-15-20
200. 34.8_SEVTC OHR Violation Letter Tracking
201. 36.4, 36.5, 37.1, 37.5, 37.7 Corrective actions for substantiated ANE are implemented Last Updated 2.24.21
202. 36.4, 36.5, 37., 37.5, 37.7 Regulatory requirements of QI programs Updated 8.12.21
203. 36.4, 36.5, 37.1, 37.5, 37.7 Regulatory requirements of RM programs 8.12.21
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249. DW98SampleDetails, undated.

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253. Community Inclusion and Integration Workgroup Charter, FY22, undated

254. Provider Capacity and Competency Workgroup Charter, FY22, undated

255. Statewide Provider Roundtable, Webinar, 10.26.21

256. Mortality Review Office/Mortality Review Committee Process and Procedure Document, Undated.

257. Email, Schodt to Zaharia, 11.3.21

258. Email, Goldman to Zaharia, 11.3.21.

259. Email, Nair to Zaharia, 11.4.21

260. Review of Failure/Late Reporting of Abuse/Neglect Allegation, undated, (SEVTC-10.11.21)

261. SEVTC Instruction Number 4060: Policy on Abuse and Neglect, 11.9.20.

Attachment 2
Interviews

Name	Title	Date
Jae Benz	Director, Office of Licensing, DBHDS	9.30.21
Taneika Goldman	Director, Office of Human Rights, DBHDS	"
Dev Nair	Assistant Commissioner, Quality Management, DBHDS	"
Jenni Schodt	Settlement Agreement Director, DBHDS	"

APPENDIX F

By

Wayne Zwick MD

MORTALITY REVIEW

To: Donald Fletcher, Independent Reviewer

From: Wayne Zwick, MD

Re: Mortality Review

Date: 10/28/21

Re: Review of the Mortality Review requirements in the Settlement Agreement, U.S. vs. Commonwealth of Virginia

The 17th period review found that the MRC (Mortality Review Committee) had made many and impressive advances toward fulfilling the requirements of the twenty-one compliance indicators (33.01-33.21) for provision V.C.5. However, further progress was needed. The MRC Annual Report for SFY 2019 did not meet the timeline of publication requirement. Data indicated the need to address unknown cause of deaths. The MRC category of death 'potentially preventable' was unable to guide the MRC to develop related quality improvement initiatives. The MRC had to depend on prior year data to determine these initiatives. The MRC's new interpretations of definitions/criteria that were used in SFY 2019 to identify potentially preventable deaths did not result in the sufficient identification of many such deaths (See Attachment A for examples). This reviewer's conclusion was that these criteria and the MRC's cause of death designations need to be revised/revamped in order to be a useful data set in guiding future recommendations and initiatives for the MRC to be able to achieve its purpose of reducing mortality rates to the fullest extent practicable. The Commonwealth had met the requirements of 33.01 – 33.10, 33.12-15, 33.17, and 33.18-33.20. The Commonwealth had not yet met the requirements of 33.11, 33.16-33.17, and 33.21.

This is the report of the 19th review period to assess the status of the Commonwealth's planning, development, and implementation of the mortality review committee membership, process, documentation, reports, and quality improvement initiatives and evaluation to comply with the mortality review provisions of the Settlement Agreement. The review encompasses a full year of progress and change (August 2020 through July 2021). Focus is on the status of Virginia's achievement of the compliance indicators that were agreed upon by the Department of Justice and the Commonwealth of Virginia and approved by the Federal Court

The MRC has continued to make advances toward fulfilling the requirements of the compliance indicators for V.C.5. With the assistance of the Office of Licensing's Specialized Investigations Unit and new regulations allowing access to medical records from several sources, the number of unknown deaths has decreased. Based on the rich data base now available, the number of deaths categorized as potentially preventable has increased. The MRC identified only 17

potentially preventable deaths in SFY 2020. However, between August 1, 2020, through July 31, 2021, the MRC identified 40 such deaths.

Based on more complete medical information, more accurate causes of death, demographic information, and other parameters has increased its ability to track reliable quality data. Tracking of action steps recommended by the MRC are monitored to closure. Based on the current submitted information from August 2020 through July 2021, a meticulous process has been put in place, with strides in reducing unreported deaths.

Methodology

The findings and conclusions of this review are based on the documents provided and information shared at the time of the telephone interviews.

The telephone interviews for this review were with the following DBHDS staff: Dr. Aplasca, Chief Clinical Officer, Robert Rigdon, MRC clinical reviewer, Whitney Queen Mortality Review Program Coordinator, Susan Moon, Director of the Office of Integrated Health.

The following documents were submitted for review during this time period:

Master Document Posting Schedules (MDPS): August 2020-July 2021

MRC Quarterly Data Reports Q4 2020, Q1 2021 Final, Q2 2021 Final, Q3 2021 Final 5.27.21

Mortality Review Meeting documentation for each of the following dates: 8/13/20, 8/27/20, 9/10/20, 9/24/20, 10/8/20, 10/22/20, 11/5/20, 11/19/20, 12/3/20, 12/17/20, 1/14/21, 1/28/21, 2/11/21, 2/25/21, 3/11/21, 3/25/21, 4/8/21, 4/22/21, 5/13/21, 5/27/21, 6/10/21, 6/24/21, 7/8/21, 7/22/21.

MRC documentation for each meeting included Electronic Morality Review Forms (eMRF) for each individual reviewed at the MRC meeting, MRC agenda, MRC minutes including attendance documentation and the DBHDS MRC Meeting Minutes Attachment.

Reports to Commissioner: MRC Quarterly Report to Commissioner Q3-4 FY 20, MRC Quarterly Report to Commissioner Q1 FY21, MRC Quarterly Report to Commissioner Q2 FY21, MRC Quarterly Report to Commissioner Q3 FY21.

Confidentiality Agreements: DBHDS Mortality Review Committee Confidentiality Agreement (for attendees of MRC)

Mortality Review Office (MRO)/Mortality Review Committee: Process and Procedure Document, revised August 2021

MRC Orientation Attendees: August 1, 2020 – July 31, 2021

MRC Action Tracking Log FY21

MRC Proposed QIIs to the QIC August 1, 2020 through July 31, 2021

DBHDS Developmental Disabilities Quality Management Plan FY2020 and Appendices 3.31.2021

Mortality Review Committee Charter Draft FY22 (there were no changes to the draft as of 9/27/21)

Report Publication Information (email 1/7/21)

SFY 2020 Annual Mortality Report: Presented by the DBHDS Mortality Review Committee November 2020)

DW0096 Report Potentially Unreported Deaths: DD VDH Death Records not in CHRIS Report; Report Date Time: 8/25/2021 12:00 VDH DOD Date Range 5/1/2021-5/2/2021 (sample)

DW0080a Report: DBHDS Incident Management Report 8/1/2021-8/2/21

Investigation Protocol Chapter: Office of Licensing Protocols: Investigations (effective 1/1/20, Revised for Indicators 4/1/20)

Investigations: Appendix C: DD Death Investigations (effective 1/1/20, Revised for Indicators 4/1/20)

PowerPoint: Quality Improvement: Putting the Pieces Together (March 26, 2020)

MRC Orientation Attendance March 26, 2020

DBHDS Mortality Review Committee Member Orientation (March 26, 2020)

September 27, 2021 QIC Meeting Materials

Weekly DW0080a Communication SIU.dcx

Monthly DW0080

Settlement Agreement Requirement

V. Quality and Risk Management System, C. Risk Management

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 90 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 nurse's 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 deliberation, 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.

Compliance indicators

The following compliance indicator table has been developed to track DOJ requirements of the MRC structure and process. Several indicators have been subdivided, as they often had several components. Evidence was then used to determine compliance with each subpart. Evidence was based on submitted documentation as well as with interviews with selected staff. The following indicators were found to have MET or NOT MET the compliance indicator metric.

CL#	Compliance Indicator Requirement	Evidence in DBHDS's submitted documentation	Status		Factual verification and analysis
			MET	NOT MET	
33.01	MRC Charter components and procedures	MRC Charter Draft FY22	**X**		This review verified that the MRC Charter Draft FY22 document includes all the elements required by Compliance Indicator 33.01 a.-h.
a.	The charge to MRC	Statement of purpose: "focus on system wide quality improvement by conducting mortality reviews of individuals who were receiving a service licensed by DBHDS at the time of death and diagnosed with an intellectual disability and /or developmental disability, utilizing an information management system to track the referral and review of these individual deaths."	X		See the verification comment for 33.01 above. Note: The MRC charge does not mention the V.C.5 Provision's goal of reducing mortality rates. Instead, the statement identifying quality improvement opportunities is a preliminary step to reducing mortality rates. This omission indicates that other entities within DBHDS are responsible for the implementation and evaluation of the quality improvement initiatives.

b.	Chair identified	Chief Clinical Officer	X		See the verification comment for 33.01 above.
b.	Executive sponsor within DBHDS	DBHDS Commissioner	X		See the verification comment for 33.01 above.
c.	Membership of MRC by role	Membership is listed as follows: Required MRC members: Chief Clinical Officer, Assistant Commissioner for Compliance, Risk Management, and Audit, Senior Director of QI, Director Community Quality, Director Office of Human Rights, Director Office of Integrated Health, MRO Clinical Manager (MRO CO Chair), OL Manager Incident Team, OL Manager Investigation Team, Office of Pharmacy Services Manager, MRO Clinical Reviewers, MRO Program Coordinator, A member with clinical experience to conduct mortality reviews who is otherwise independent of the State. Advisory Members - DBHDS Assistant Commissioner, Division of Quality Assurance and Governmental Relations, Representative from DBHDS Office of Data Quality and Visualization, Representative Department of Medical Assistance Services, Representative Department of Health, Representative Dept of Social Services, Representative from Office of Chief medical Examiner,	X		See the verification comment for 3.01 above.

		Representative from Community Services Board, other subject matter experts such as representatives from a DD Provider or Advocacy Organizations.			
d.	Responsibilities of chair and members	"The committee chair shall be responsible for ensuring the committee performs it's functions, consideration and, as appropriate, approval of quality improvement activities and MRC core processes."	X		See the verification comment for 33.01 above.
e.	Frequency of meetings	"The MRC meets at a minimum, on a monthly basis or more frequently as necessary to conduct mortality reviews within 90 days of death."	X		See the verification comment for 3.01 above.
f.	Review of unexplained and unexpected deaths	"The Clinical Reviewers document all relevant information onto the electronic Mortality Review Form, and submits each clinical case summary for final review. The COO or CM reviews all clinical case summaries and assigns a Tier category based on the sequential information related to the events surrounding that individual's death. The criteria for each Tier Category are also utilized. …. A facilitated discussion is conducted during MRC meetings for all Tier I cases and those cases where the Tier category could not be determined without MRC discussion and decision making…. A case is categorized as Tier 1 when any of the following criteria exists: Cause of death	X		See the verification comment for 33.01 above.

		cannot clearly be determined or established or is unknown. Any unexpected death, abuse or neglect is specifically documented, documentation of investigation by or involvement of law enforcement or similar agency, specific or well-defined risks to safety and well-being are documented."			
f.	Components of a complete mortality review	"Standard operating procedures: The Specialized Investigation Unit (SIU) reviews all deaths of individuals with I/DD reported to DBHDS through its incident reporting system. Available records and information are obtained for individuals with I/DD who were receiving a licensed service, and the Office of Licensing (OL) Investigation is submitted to the MRO within 45 business days of the date of the death was reported. The MRO then has 4 weeks after receipt of the OL Investigation to complete a case review. Within 90 calendar days of a death, the MRT complies a review summary of the death. This includes development of succinct clinical case summaries within 2 weeks of reviewing and documenting the availability or unavailability of: medical records including healthcare provider and	X		See the verification comment for 33.01 above.

		nursing notes for 3 months preceding death, incident reports for 3 months preceding death, most recent individualized service program plan, medical and physical exam records, death certificate and autopsy report (when performed), any evidence of maltreatment related to the death, interview as warranted, any person having information regarding the individual's care. When additional documents are needed, the MRT will request these records from appropriate entities per Virginia Code. The clinical reviewers document all relevant information on the electronic Mortality Review Form. The CCO or CM reviews all clinical case summaries are assigned a Tier category based on the sequential information related to the events surrounding that individual's death. The criteria for each Tier category are also utilized. At each MRC meeting, members perform comprehensive clinical mortality reviews, evaluate the quality of the decedent's licensed services, identify risk factors and gaps in service, recommend QI strategies, review OL corrective action plans related to required recommendations, to ensure no further action is required for inclusion in			

		meeting minutes, make additional recommendations for further investigation and or action by other DBHDS Offices represented by MRC members, assign recommendation and or action to specific MRC members, review and track the status of previously assigned recommended actions to ensure completion, and may interview any persons having information regarding the individual's care."			
f.	Standards for closing a review	"For each case reviewed, the MRC seeks to identify: the cause of death, if death was expected, whether death was potentially preventable, any relevant factors impacting the individual's death, any other findings that could affect the health, safety, and welfare of these individuals, whether there are other actions that may reduce these risks, … make and document relevant recommendations and or interventions. Documentation is located in the Meeting minutes, Summary Report, Action Tracking Log, and/or on the electronic Mortality Review Form. The MRC will make recommendations (including but not limited to QIIs) in order to reduce mortality rates to the fullest extent practicable. The case may be closed or	X		See the verification comment for 33.01 above.

		pended. If all determinations are made, the case is closed by the committee. If additional information is needed in order to make a determination, the case is pended until the next meeting. … A pended case remains open until the following meeting, when the assigned committee member provides an update, or specific information has been received, as requested. If all determinations can be made, the pended case is closed by the committee."			
f.	Standards for Committee quorum	"A quorum is 50% of voting membership plus one, with attendance of at least (one member may satisfy two roles): a medical clinician (medical doctor, nurse practitioner, or physician assistant), a member with clinical experience to conduct mortality reviews, a professional with quality improvement expertise, and a professional with programmatic/operational expertise"	X		See the verification comment for 33.01 above.
f.	Standards for Recusal from case review	"members must recuse themselves from MRC proceedings if a conflict of interest arises, in order to maintain neutrality and credibility of the MRC mortality review process. Conflict of interest exists when an MRC member has a financial, professional, or personal interest that could directly influence MRC determinations, findings, or recommendations, such	X		See the verification comment for 33.01 above.

		as: The MRC member, or an individual from the member's family, was actively involved in the care of the decedent, the MRC member may have participated in a facility or institutional mortality review of the decedent, the MRC member, or an individual from the member's family, has a financial interest or investment that could be directly affected by the mortality review of the decedent, to include employment, property interests, research, funding or support, industry partnerships, and consulting relationships. Should a conflict of interest arise during the review process, the MRC member will: immediately disclose the potential conflict of interest and cease participation in the case review related to the existing or potential conflict of interest and disclose the conflict of interest privately to the Chair/Co-Chair, or publicly to the members in attendance. The RC will then halt discussion of the conflict of interest case, move on to the next case and place the conflict of interest case at the end. This allows the MRC member with a conflict of interest to remain for the preview of other cases, and then leave the proceedings prior to the discussion of			

		the conflict of interest case.“			
	Standards for Confidentiality protections for reviews	“all MRC members and other person who attend closed meetings of the MRC are required to sign a confidentiality agreement form. Members shall notify the MRC Co-Chair and or MRO program Coordinator prior to having a guest attend a meeting so that arrangements may be made for the guest to sign the confidentiality agreement form before being permitted to attend. Member confidentiality forms are valid for the entire term of the MRC membership, and guest confidentiality forms are valid for repeat attendance at MRC meetings. Additionally, “to ensure confidentiality and adhere to mandated privacy regulations and guidelines, case reviews are provided to MRC members during the meeting only.”	X		See the verification comment for 33.01 above.
g.	Definition of unexplained deaths	“An unexplained death is considered an unexpected death.”	X		See the verification comment for 33.01 above.
g.	Definition of unexpected deaths	“An unexpected death denotes a death that occurred as a result of a condition that was previously undiagnosed, occurred suddenly, or was not anticipated. Deaths are considered unexpected when they: are not anticipated or related to a known terminal illness or medical condition, are related to injury, accidents,	X		See the verification comment for 33.01 above.

		inadequate care, or are associated with suspicion of abuse or neglect. An acute medical event that was not anticipated in advance nor based on an individua's known medical condition (s) may also be determined to be an unexpected death."			
h.	Requirements for periodic review and analysis at individual service level	"Performance Measure Indicators (PMIs): include outcome measures established by DBHDS and reviewed by the DBHDS QIC. Outcome measures focus on what individuals receive as a result of the services and supports they receive. The PMIs allow for tracking the efficacy of preventative, corrective, and improvement initiatives. … DBHDS uses these PMIs to identify systemic weaknesses or deficiencies, recommends and prioritizes quality improvement initiatives to address identified issues for QIC review and approval."	X		See the verification comment for 33.01 above.
h.	Requirements for periodic review and analysis for system level fact	"Performance Measure Indicators include output measures established by DBHDS and reviewed by the DBHDS QIC. Output measures focus on what the system provides or the products it uses. The PMIs allow for tracking the efficacy of preventative, corrective, and improvement initiatives. … DBHDS uses these PMIs to identify systemic weaknesses or deficiencies, recommends and	X		See the verification comment for 33.01 above.

		prioritizes quality improvement initiatives to address identified issues for QIC review and approval."			
h.	Develop and implement QI initiatives to reduce mortality rates	"The MRC documents recommendations for systemic Quality Improvement Initiatives (QIIs) coming from patterns of individual reviews on an ongoing basis, and analyzes patterns that emerge from any aggregate examination of mortality data. From this analysis, the MRC makes one recommendation per quarter for systemic QIIs "	X		See the verification comment for 33.01 above.
h.	Reporting of QI initiatives to the QIC	"…the MRC makes one recommendation per quarter for systemic QIIs, and reports these recommendations to the QIC (quarterly). …On a quarterly basis, the MRC also prepares and delivers to the QIC a report specific to the committee's findings."	X		See the verification comment for 33.01 above. The MRC charter specified the DBHDS process for reporting of QI initiatives to the QIC.
C1#	Compliance Indicator Requirement	Evidence in DBHDS's submitted documentation	Status MET	Status NOT MET	Factual verification and analysis
33.02	Current MRC membership	The MRC membership is specified in the MRC charter. MRC meeting minutes attendance rosters includes this information.	**X**		This study verified that DBHDS achieved the requirement for Compliance indicator 33.02 a.-g. This determination was made based on a review of the attendance rosters for each MRC meeting which verified the membership's

					attendance, and the minutes which verified the participation of the required members.
a.	DBHDS Chief Clinical Officer (former title, Medical Director)	MRC meeting minutes attendance rosters with members identified with title/department	X		See the verification comments for 33.02 above. This was fulfilled by the CCO (MD) being the chair; additionally, the co-chair was the MRO clinical manager (NP)
b.	DBHDS Senior Director of Clinical Quality Management (former Asst. Commissioner for QI)	Same as above	X		See the verification comments for 33.02 above. There were several staff representing QI, either as primary attendees or as alternates through the 12 months of MRC meetings reviewed: Clinical QI (2), Compliance/ Risk Management/ Audit (2), Community QI (1)
c.	Independent practitioner	One MD who was the independent clinician for the MRC	X		See the verification comments for 33.02 above. A review of the MRC meeting minutes verified that the Independent practitioner attended 21 of 23 (91.3%) of the MRC meetings during FY2020.
d.	Medical doctor	COO and independent practitioner	X		See the verification comments for 33.02 above.

e.	Nurse	MRC meeting minutes attendance rosters with members identified with title/department	X		See the verification comments for 33.02 above. RN (4) indicated on attendance roster
f.	QI staff	Same as above	X		See the verification comments for 33.02 above. There were several staff representing QI, either as primary attendees or as alternates: Clinical QI (2), Compliance/ Risk Management/ Audit (2), Community QI (1)
g.	Programmatic/ operational staff	Same as above	X		See the verification comments for 33.02 above. DMAS member (1), incident management (3), compliance (2), OHR (2), specialized investigation unit (2), OIH (2), MR coordinator (1), SA member (1)
C1#	Compliance Indicator Requirement	Evidence in DBHDS's submitted documentation	Status MET	Status NOT MET	Factual verification and analysis
33.03	MRC member training topics to members		**X**		
a.	Orientation to MRC Charter scope, mission, vision, charge, and function of the MEC	A copy of the power-point "Mortality Review Committee Member Orientation March 26, 2020" was submitted. This reviewed the purpose of the committee, mission and vision, meeting requirements, quorum requirements, role of	X		In the document 'MRC Orientation Attendees August 1, 2020- July 31, 2021" provided training for attendees new to the MRC during the 19th study period. See Attachment 2

		mortality review team, role of MRC members, confidentiality procedures, tasks of MRC, data analysis. A document entitled 'MRC Orientation Attendees" was submitted, which documented those attendees that completed the orientation in the 17th review period.			for details. There were 2 members who had attended MRC meeting, as observers only, and were trained prior to participating as members. The CCO reported that they had both signed confidentiality statements.
b.	Prior to participation, review policies, processes, and procedures of the MRC	See above	X		Same as above
c.	Education on the role/responsibilities of members	See above	X		Same as above
d.	Training on continuous QI principles	See above	X		Same as above
C1#	Compliance Indicator Requirement	Evidence in DBHDS's submitted documentation	Status MET	Status NOT MET	Factual verification and analysis.
33.04	MRC functional requirements		**X**		
33.04	Frequency: meets at least monthly	Submitted were copies of the MRC meeting minutes and attachments for 24 meetings from 8/13/20 to 7/22/21.	X		This study verified that DBHDS achieved the requirements for Compliance Indicator 33.04. This determination was made based on a review of MRC meeting minutes and Attachments to the MRC Meeting Minutes. See Attachment 3 for dates of MRC minutes and attachments.
33.04	Quorum met for each monthly meeting	The MRC charter defines a quorum as: "50% of voting	X		This study verified that DBHDS

		membership plus one, with attendance of at least (one member may satisfy two roles): A medical clinician, a member with clinical experience to conduct mortality reviews, a professional with quality improvement expertise, and a professional with programmatic operational expertise."			achieved the requirements for Compliance Indicator 33.04 a.-e. Attendance rosters were included in the minutes of the MRC meetings. which met twice monthly. The Quorum requirement of a medical clinician, a member with clinical experience to conduct mortality reviews, a professional with quality improvement expertise, and a professional with programmatic / operational expertise was met at each meeting. Additionally, at least 50% of voting members attended each time. There were 14 listed as required voting members. A quorum required 8 members to attend to meet the threshold of a quorum. The attendance ranged from 13 to 17 members at each meeting, of which 10 to 14 were voting members, exceeding the

					minimal number required.
a.	Medical Clinician (medical doctor, nurse practitioner, or physician assistant) required for quorum	MRC meeting minutes attendance roster	X		This study verified that DBHDS achieved the requirements for Compliance Indicator 33.04 a. From 8/13/20 through 7/22/21 there was a medical clinician at each meeting.
b.	Clinician with experience in mortality review required for quorum	As above	X		This study verified that DBHDS achieved the requirements for Compliance Indicator 33.04 b. From 8/13/20 through 7/22/21 there was a clinician with experience in mortality review at each meeting.
c.	QI professional staff required for quorum	As above	X		This study verified that DBHDS achieved the requirements for Compliance Indicator 33.04 c. From 8/13/20 through 7/22/21 there was a QI professional staff at each meeting.
d.	Programmatic/operational professional staff required for quorum	As above	X		This study verified that DBHDS achieved the requirements for Compliance Indicator 33.04 d. From 8/13/21 through 7/22/21 there was a programmatic/ operation

					professional staff at each meeting
e.	One member may satisfy up to two roles	Information only. Several members had more than one role. In most cases, several attendees represented the same role, providing a robust review.	X		This study verified that DBHDS achieved the requirements for Compliance Indicator 33.04 e.
C1#	Compliance Indicator Requirement	Evidence in DBHDS's submitted documentation	Status MET	Status NOT MET	Factual verification and analysis
33.05	DBHDS information management system		**X**		
33.05	Track referral and review of individual deaths	A document entitled 'Mortality Review Committee Action Tracking Log' documented the actions taken and outcomes for each individual in which there was an MRC recommendation. Along with date completed.	X		This review verified that the 'Mortality Review Committee Action Tracking Log' identified recommendations from 8/13/20 - 6/24/21. The MRC tracked all recommendations through to closure as of 8/26/21 for MRC meetings from 8/13/20 - 6/24/21. See Attachment 4.
33.05	Track recommendations of the MRC at provider level	A document entitled 'Mortality Review Committee Action Tracking Log' documented the actions taken and outcomes for each individual in which there was an MRC recommendation. Along with date completed. This was evidence of closure of provider concerns. Each MRC meeting minutes includes a section for MRC Recommendation Update which reviews updates for pending actions on the Action Tracking Log.	X		This review verified that the 'Mortality Review Committee Action Tracking Log' identified recommendations from 8/13/20 - 6/24/21. The MRC tracked all recommendations through to closure as of 8/26/21 for MRC meetings from 8/13/20 - 6/24/21 'Mortality Review Committee Action Tracking Log', see above

					details of tracking of individuals through to closure as of 8/26/21 for MRC meetings from 8/13/20 - 6/24/21. See Attachment 4.
33.05	Track QI initiatives approved by MRC chair for implementa-tion.	When there was implementation of QI initiatives, tracking was reflected in the minutes of the MRC at periodic intervals	X		This study verified that DBHDS achieved the requirements for Compliance Indicator 33.05. See Attachment 5 for details.
C1#	Compliance Indicator Requirement	Evidence in DBHDS's submitted documentation	Status MET	Status NOT MET	Factual verification and analysis
33.06	Licensing responsibility with death reviews		**X**		
33.06	DBHDS licensed providers report deaths through incident reporting system within 24 hours of discovery	The 'Incident Management Report' includes information concerning several dates relevant to timely reporting: Incident Date, Discovery Date, Enter Date, Reporting Delay (hours), Hours over 24 hours requirement, and late reporting. From this information, the date of death and the date reported are documented on the 'Mortality Review Form' completed by the mortality record reviewer for the MRC.	X		This study verified that the Office of Licensing maintained its system and the operations of its Investigations Unit which were the basis for DBHDS achieving Met determinations with the Compliance Indicator 33.06 during the 17th Review Period. During the study, interviews and review of other documentation related to individual cases found data that the Office of Licensing Investigations Team operates

					consistent with its planned structure and continues to meet the timelines required by these C1s.
33.06	DBHDS Licensing Investigations Team reviews all deaths of individuals with a developmental disability reported to DBHDS incident reporting system	Submitted was a document entitled 'Office of licensing protocols investigations' reviewed for indicators 4/1/20. This document reviewed the process/procedures in place for investigation by OL. By the Code of Virginia, the commissioner is required to investigate promptly all complaints.	X		This study verified that DBHDS achieved the requirements for this Compliance Indicator of 33.06. The MRC Master Document Posting Schedule (MDPS) provided this data which was reviewed. See Attachment 6 for details.
33.07	Initial review within 24 hrs. of death reported to DBHDS or next business day	In the document Office of Licensing protocols investigations, reviewed for indicators 4/1/20', serious incidents are to be reported using the department's web-based reporting application and by telephone to the appropriate designee with in 24 hours of discovery. The Incident Management Unit reviews and triages serious incident reports and if the team recommends an investigation the Licensing specialist/Investigator is notified of the incident. Region 3 and 4 have this process in place. For Regions 1,2 and 5, the LS reviews the CHRIS entries within 24 hours of receipt and make a determination whether an investigation is indicated. All DD deaths	**X**		This study verified that the Office of Licensing maintained its system and the operations of its investigations Unit which were the basis for DBHDS achieving Met determinations with the Compliance Indicator 33.07 during the 17th Review Period. During the study, interviews and review of other documentation related to individual cases found data that the Office of Licensing Investigations Team operates consistent with its

		are immediately forward to the Specialized investigation Unit manager or designee for triage by a SIU licensing investigator. This document has a section subtitled 'Timeline for initiating an investigation and issuing a citation', in which the guidance indicates all investigations must be opened in OL within 3 business days of incident. This document also reviews criteria for closure of the investigation. All investigations are to be closed within 60 business days of death.			planned structure and continues to meet the timelines required by these C1s.
33.08	Immediate licensing investigation if concern of abuse/neglect or concern of imminent and substantial threat to health, safety and welfare of other individuals, with action steps as appropriate	Any death of an individual with developmental disabilities initiates an investigation. This document also indicates the OL SIU will investigate all unreported deaths of the IDD population.	**X**		This study verified that the Office of Licensing maintained its system and the operations of its investigations Unit which were the basis for DBHDS achieving Met determinations with the Compliance Indicator 33.08 during the 17th Review Period. During the study, interviews and review of other documentation related to individual cases found data that the Office of Licensing Investigations Team operates consistent with its planned structure

					and continues to meet the timelines required by these C1s.
33.09	Licensing provides available record and information it obtains and the completed investigation report to the MRC within 45-business days of date death reported on at least 86% of deaths required to be reviewed by MRC	The document indicates investigations are to be closed within 60-business days of death. The OL verifies that CAPs were implement within 45-days of their start date (30-business days for OL). The 'Master Documents Posting Schedule (MDPS) records for each death, the final due date 45- business days from date of report, and the date of posting of the OL investigation. This was provided for each month from August 2020 through July 2021.	**X**		This study verified that DBHDS achieved the requirements for this Compliance Indicator of 33.09. The MRC Master Document Posting Schedule (MDPS) provided this data which was reviewed. See Attachment 7 for details. Additionally, this study reviewed the eMRFs, which documented that licensing reports were recorded as being received on 330 of 340 (97%) applicable individuals reviewed at the MRC.
C1#	Compliance Indicator Requirement	Evidence om DBHDS's submitted documentation	Status MET	Status NOT MET	Factual verification and analysis
33.10	MRC process in identifying deaths subject to review		**X**		
	Incident reporting system queried monthly to extract reports of all deaths with an ID/DD dx receiving licensed ID/DD service and /or residing in training center	Submitted was a document entitled: 'Mortality Review Office/Mortality Review Committee Process and Procedure Document. ´This document provides the detailed process by which all deaths with an ID/DD dx are tracked. "For licensed DD providers, the SIU Manager runs report DW-	X		This study verified that DBHDS achieved the requirements for this Compliance Indicator of 33.10a. See Attachment 8.

		0080a weekly and forwards results to the Mortality Review Office Program Coordinator. (Step 1) This information is added to the MDPS and verifies any discrepancies. Folders are then created for these decedents on the MRC shared drive. On a monthly basis, the SIU and MROPC finalize the list of deaths based on DW-0080a. (Step 2). The MROPC uploads the finalized report, and notifies DQV when completed. DQV then accesses that month's folder and adds those decedents to the electronic Mortality Review Form access database. DQV queries the incident management system monthly, to identify deaths of individuals with an I/DD diagnosis who were residing in a Training Center or Mental Health Facility and adds those deaths to the eMRF. The MROPC adds any I/DD state facility deaths to the MDPS obtained from the state facility 45-day reports submitted to the MRO." (Step 3)			
a.	Extracted reports included in data tracking log for MRC review	All the above reports are added to the MDPS for tracking purposes.	X		This study verified that DBHDS achieved the requirements for this Compliance Indicator of 33.10a. The Master Document Posting Schedules (MDPS)

					provides evidence of the posting.
33.11	MRC clinical reviewers review information on data tracking log and determine if death is unexplained or unexpected and requires review by MRC	The MRT Clinical Reviewers complete a succinct clinical summary of the events leading up to each decedent's death. … The Chief Clinical Officer or MRT Clinical Manager completes a preliminary review of all clinical case summaries using the following Tier system: A case is categorized as Tier 1 when any of the following exists: 1. cause of death cannot clearly be determined or established, or is unknown. 2. Any unexpected death- This includes any death that was not anticipated or related to a known terminal illness or medical condition, related to injury, accident, inadequate care or associated with suspicions of abuse or neglect. A death due to an acute medical event that was not anticipated in advance nor based on an individual's known medical condition (this may also be determined to be an unexpected death). 3, Abuse or neglect is specifically documented. 4. documentation of investigation by or involvement of law enforcement or similar agency (including forensic). 5. Specific or well-defined risk to safety and well-being are documented. A case is categorized as Tier 2 when all the first 4 criteria	**X**		This study verified that DBHDS achieved the requirements for this Compliance Indicator of 33.11. An electronic 'Mortality Review Form' is completed by the MRC clinical reviewer for each death reported. This information is discussed at the DBHDS MRC for each case presented at that committee meeting. For the 351 mortalities reviewed at the MRC meetings from August 202 through July 2021, there were 351 electronic Mortality Review Forms (eMRF) completed. See Attachment 9. As the eMRF is completed, is logged into the Master Document Posting Schedule indicating the completion of preparation of documents ready for the next MRC meeting. The DBHDS MRC Meeting Minutes

		exists: 1. cause of death can clearly be determined or established, 2. no documentation of abuse of neglect is noted, 3. no documentation of investigation by or involvement of law enforcement or similar agency, is cited, 4. no documentation of specific or well-defined risk to safety and well-being are noted. After the category is determined, the case is moved to the Committee Review workflow of the Access database and is ready for presentation to the MRC." As documented in the MRC minutes, Tier 1 category deaths require MRC discussion, guidance, and deliberation. All I/DD deaths are categorized as either Tier 1 or Tier 2."			Attachment provide evidence that each death reviewed by the MRC is categorized as Tier 1 or Tier 2. See Attachment 10.
33.12	DBHDS data crosslinked with DOH to determine if death certificate on file results provided to DBHDS to attempt to identify deaths not reported through incident report system.	To ensure deaths not reported through the DBHDS Incident reporting system are captured, each month "DBHDS provides the identifying information of individuals in the Waiver Management System who receive DBHDS licensed services on a monthly basis to the Virginia DOH. DOH then identifies the names in the Waiver Management System for which a death certificate is on file. The results are provided to DBHDS and used by DBHDS to attempt to identify deaths that were not reported through the incident management system." This leads to a	**X**		This study verified that DBHDS achieved the requirements for this Compliance Indicator of 33.12, based on data from the most recent review period of August 2020 through July 2021. Information was located in the document: 'Potential Unreported Deaths Log' for each month reviewed. See Attachment 11.

		monthly list of 'Potential Unreported Deaths' that must then be further researched to determine if they were receiving services through DBHDS, or were on a wait list, or were the result of a computer linking problem, data entry error, etc.			
33.12	DBHDS Office of Licensing investigates all unreported deaths identified by this process	"The DBHDS Office of Licensing will investigate all unreported deaths of DBHDS licensed providers identified by this process and take appropriate action in accordance with DBHDS licensing regulations and protocols …The SIU will track death investigations initiated by this process, on the MDPS (Master Document Posting Schedule)."	X		This study verified that DBHDS achieved the requirements for this Compliance Indicator of 33.12. see Attachment 12 for details.
33.12	DBHDS Office of Licensing takes appropriate action	"The DBHDS Special Investigations Unit (SIU) reviews all deaths of individuals with an I/DD diagnosis reported to DBHDS through the incident report system."	X		This study verified that DBHDS achieved the requirements for this Compliance Indicator of 33.12. See Attachment 13.
C1#	Compliance Indicator Requirement	Evidence in DBHDS's submitted documentation	Status MET	Status NOT MET	Factual verification and analysis
33.13	MRC process consistent with charter			**X**	
33.13	86% of unexplained/ unexpected deaths reported through DBHDS incident reporting system have a completed MRC review within 90-days of death.	The Mortality Review Committee Charter Draft - FY22 states: "Within 90 calendar days of a death (and for any unreported deaths), the Mortality Review Team (MRT) compiles a review summary of the death. This includes development		X	This study verified that DBHDS did not achieve the requirements for this Compliance Indicator of 33.13. 100% of unexpected deaths

		of succinct clinical case summaries …" Additionally, the MRC charter states "The MRC prepares and delivers to the DBHDS Commissioner a report of deliberations, findings, and recommendations, if any, for 86% of deaths requiring review within 90-days of the death." To track compliance with this indicator, DBHDS data for completion of mortality reviews is listed in the 'MRC Data Reports'. See Attachment 14.			were reviewed by the MRC. However, beginning with the 4/22/21 MRC meeting, the number of unexplained/ unexpected deaths with completed MRC review within 90-days decreased. See Attachment 15.
33.14	Availability of specific key documents or documentation of the review or unavailability of medical records		**X**		
a.	Availability of: medical records including physician case notes, nurses' notes, and all incident reports, for the 3 months preceding death	Th Mortality Review Committee Charter Draft FY22 documented the documents to be reviewed by or their unavailability for review by the Mortality Review Team.	X		This study verified that DBHDS did achieve the requirements for Compliance Indicator 33.14a.
a.	Availability or not of most recent individualized program plan	The Mortality Review Committee Charter Draft - FY 22 states the MRT complies a review summary of the death. This includes development of succinct clinical case summaries within two weeks of reviewing and document the availability or unavailability, of: most recent individualized service program plan.	X		This study verified that DBHDS achieved the requirements for this sub Compliance Indicator of 33.14a. See Attachment 17.
a.	Availability of physical exam records	The Mortality Review Committee Charter Draft -	X		This study verified that DBHDS

		FY 22 states the MRT complies a review summary of the death. This includes development of succinct clinical case summaries within two weeks of reviewing and document the availability or unavailability, of: Medical and physical examination records.			achieved the requirements for this sub Compliance Indicator of 33.14. See Attachment 17.
a.	Availability of death certificate and autopsy report (if applicable)	The Mortality Review Committee Charter Draft - FY 22 states the MRT complies a review summary of the death. This includes development of succinct clinical case summaries within two weeks of reviewing and document the availability or unavailability, of: Death certificates and autopsy reports.	X		This study verified that DBHDS achieved the requirements for this sub Compliance Indicator of 33.14a. See Attachment 17.
a.	Any evidence of maltreatment related to death	The Mortality Review Committee Charter Draft - FY 22 states the MRT complies a review summary of the death. This includes development of succinct clinical case summaries within two weeks of reviewing and document the availability or unavailability, of: Any evidence of maltreatment related to death.	X		This study verified that DBHDS achieved the requirements for this sub Compliance Indicator of 33.14a. See Attachment 17. .
b.	Interviews as warranted for any person(s) having information regarding individual's care	The Mortality Review Committee Charter Draft - FY 22 states the MRT complies a review summary of the death. This includes development of succinct clinical case summaries within two weeks of reviewing and	X		This study verified that DBHDS achieved the requirements for this sub Compliance Indicator of 33.14b. See Attachment 18.

		document the availability or unavailability, of: Interviewing, as warranted, any persons having information regarding the individual's care.			
33.15	MRC report prepared and delivered to DBHDS Commissioner of deliberations, findings, and recommendations for 86% of deaths requiring review within 90 days of death	The Mortality Review Committee Charter Draft – FY22 states "The MRC prepares and delivers to the DBHDS Commissioner a report of deliberations, findings, and recommendations, if any, for 86% of deaths requiring review within 90 days of the death."		**X**	This study verified that DBHDS achieved all the requirements for this sub Compliance Indicator of 33.15. except completing and submitting reports to the Commissioner within 90 days of the death (See 33.13 above.) Documents used in verification included: Quarterly reports: MRC Quarterly Report to Commissioner Q3-4 FY2020, MRC Quarterly Report to Commissioner Q1 FY2021, MRC Quarterly Report to Commissioner Q2 FY2021, MRC Quarterly Report to Commissioner Q3 FY2021 See Attachment 19
33.15	When MRC makes no recommendations, this is stated, that no recommendations were warranted	The Mortality Review Committee Charter Draft – FY22 states: "If the MRC elected not to make any recommendations, documentation will affirmatively state that no recommendations were warranted."	X		This study verified that DBHDS achieved the requirements for this sub Compliance Indicator of 33.15.

					For each MRC meeting, a DBHDS Summary Report documented whether a recommendation was made or not made/not considered applicable.
33.16	MRC collects and analyzes mortality, data to identify trends, patterns, and problems at the individual service delivery and systemic levels and develop and implement QII to reduce mortality rates to the fullest extent practicable	The Mortality Review Committee Charter Draft – FY22 states "Through mortality reviews, data collection, and analysis of data, including trends, patterns, and problems at individual service delivery and systemic levels, the MRC identifies areas for development of QIIs." Additional statements include (at the individual service level): "… Evaluate the quality of the decedent's licenses services …identify risk factors and gaps in service and recommend quality improvement strategies to promote safety, freedom from harm, and physical, mental, and behavioral health and well-being. … the MRC will determine the cause of an individual's death, whether the death was expected, and if the death was potentially preventable. The MRC also develops and assigns specific relevant actions when needed." (at the systemic level): The MRC provides ongoing monitoring and data analysis to identify trends	**X**		This study verified that DBHDS achieved the requirements for this Compliance Indicator of 33.16. The following documents provided evidence of this. Power Point: "MRC Proposed QIIs to the QIC August 1, 2020, through July 31, 2021", Virginia DBHDS SFY 2020 Annual Mortality Report, MRC Quarterly Reports to Commissioner, MRC Action Tracking LOG FY21, and MRC Quarterly Data Reports. The MRC identified 40 potentially preventable deaths between August 1, 2020, through July 31, 2021. Whereas in SFY 2020, the MRC identified only 17 such deaths. For detailed evidence from a

		and/or patterns and then makes recommendations to promote the health, safety and well-being of said individuals…DBHDS develops and implements quality improvement initiatives (QIIs), either regionally or statewide, as recommended by the MRC and approved by the DBHDS Commissioner, to reduce mortality rates to the fullest extent practicable. On a quarterly basis, DBHDS staff assigned to implement QIIs will report data related to the QIIs to the MRC to enable the committee to track implementation." Submitted documentation which provided evidence for this indicator included: Virginia DBHDS SFY 2020 Annual Mortality Report, Power Point: "MRC Proposed QIIs to the QIC August 1, 2020, through July 31, 2021", MRC Quarterly Reports to Commissioner, MRC Action Tracking LOG FY21, and MRC Quarterly Data Reports.			sample review, see Attachment 20.
C1#	Compliance Indicator Requirement	Evidence in DBHDS's submitted documentation	Status MET	Status NOT MET	Factual verification and analysis
33.17	MRC Annual Report content		**X**		
33.17	Completed within 6 months of end of fiscal or calendar year	The Virginia DBHDS SFY 2020 Annual Mortality Report was "presented by the DBHDS Mortality Review Committee November 2020". The	X		This study verified that DBHDS achieved the requirements for this Compliance Indicator of 33.17.

		original date of posting was 12/18/20.			Virginia DBHDS SFY 2020 Annual Mortality Report: Timeframe of FY20 is 7/1/19-6/30/20. The title page indicated it was completed November 2020. It was posted for public access 12/18/20 (evidence was email confirming this date for the FY 20 Annual Report.
	The annual report will, at a minimum include:				
i.	# and cause of deaths	Virginia DBHDS SFY 2020 Annual Mortality Report includes this information	X		This study verified that DBHDS achieved the requirements for this sub-Indicator 33.17i. See Attachment 21 for evidence in Virginia DBHDS SFY 2020 Annual Mortality Report
ii.	Crude mortality rate	Same as above	X		This study verified that DBHDS achieved the requirements for this sub-Indicator of 33.17ii See Attachment 21
iii.	Crude mortality by residential settings	Same as above	X		This study verified that DBHDS achieved the requirements for this sub-Indicator of 33.17iii. See Attachment 21
iv.	Crude mortality rate by age	Same as above	X		This study verified that DBHDS achieved the requirements for

					this sub-Indicator of 33.17iv. See Attachment 21
iv.	Crude mortality rate by gender	Same as above	X		This study verified that DBHDS achieved the requirements for this sub-Indicator of 33.17iv. See Attachment 21
iv.	Crude mortality rate by race	Same as above	X		This study verified that DBHDS achieved the requirements for this sub-Indicator of 33.17iv. See Attachment 21
v.	Analysis of patterns of mortality:				
v.	By age	Virginia DBHDS SFY 2020 Annual Mortality Report includes this information	X		This study verified that DBHDS achieved the requirements for this sub-Indicator of 33.17v. See Attachment 21
v.	By gender	Same as above	X		This study verified that DBHDS achieved the requirements for this sub-Indicator of 33.17v. See Attachment 21
v.	By race	Same as above	X		This study verified that DBHDS achieved the requirements for this sub-Indicator of 33.17v. See Attachment 21
v.	By residential settings and DBHDS facilities	Same as above	X		This study verified that DBHDS achieved the requirements for this sub-Indicator of 33.17v. See Attachment 21

v.	By service program	Same as above	X		This study verified that DBHDS achieved the requirements for this sub-Indicator of 33.17v. See Attachment 21
v.	By cause of death	Same as above	X		This study verified that DBHDS achieved the requirements for this sub-Indicator of 33.17v. See Attachment 21
b.	Summary of findings released publicly	This was confirmed in an email submitted as documentation for this indicator.	X		From email concerning 'report publication information.' Date of release: 12/18/20 posted to DBHDS website: https://dbhds.virginia.gov/quality-management.
C1#	Compliance Indicator Requirement	Evidence in DBHDS's submitted documentation	Status MET	Status NOT MET	Factual verification and analysis
33.18	Documents recommendations for systemic QI initiatives from patterns of individual reviews or patterns that emerge from any aggregate examination of mortality data annually or twice annually.	The DBHDS SFY 2020 Annual Mortality Report includes a section on 'Recommendations'. In this section the following is states: "An important component of health and safety oversight within DBHDS involves the analysis and review of mortality data to identify important patterns and trends that may help to decrease risk factors; provide information to guide system enhancements through process improvements; and determine recommendations in response to these findings.	**X**		This study verified that DBHDS achieved the requirements for this Compliance Indicator of 33.18. See Attachment 22.

		The DBHDS DD MRC documents recommendations for systemic quality improvement initiatives coming from patterns of individual reviews on an ongoing basis … From this analysis, … the DBHDS DD MRC also makes four recommendations annually for systemic quality improvement initiatives, and reports these recommendations to the QIC and the DBHDS Commissioner."			
33.19	MRC makes 4 recommendations for systemic QI initiatives based on aggregate patterns or trends annually	MRC recommendations a are located in the SFY 2020 Annual Mortality Report. This is an annual document which included 4 recommendations from the MRC. Further evidence of ongoing MRC recommendations that became proposed QI initiatives were provided by a submitted document entitled 'MRC Proposed QIIs August 1, 2020 to July 31, 2021."	**X**		This study verified that DBHDS achieved the requirements for this Compliance Indicator of 33.19. See Attachment 22 and Attachment 23.
33.19	MRC reports these recommendations to the QIC and the DBHDS Commissioner	Submitted documents reviewed for compliance of this indicator included: 'MRC Proposed QIIs to the QIC August 1, 2020 through July 31, 2021' (which includes more recent information on ongoing recommendations and initiatives beyond the Annual Mortality Report.) The 9/27/21 QIC minutes.	X		This study verified that DBHDS achieved the requirements for this Compliance Indicator of 33.19. See Attachment 24.

		The following MRC Quarterly Reports to the Commissioner: 'MRC Quarterly Report to the Commissioner: Q3-4 FY20, Q1 FY21, Q2 FY21, and Q3 FY21.			
33.20	DBHDS develops and implements QI initiatives, either regionally or statewide, as recommended by MRC and approved by DBHDS Commissioner	The submitted document: 'MRC Proposed QIIs to the QIC August 1, 2020 through July 31, 2021' reviewed the QI initiatives that were approved and implemented in the most recent time period available for review. Progress and completion of QII initiatives for SFY20 were included in the MRC Annual Mortality Report.	**X**		This study verified that DBHDS achieved the requirements for this Compliance Indicator of 33.20. See Attachment 24.
33.20	DBHDS staff on quarterly basis report data related to the QI initiatives, to the MRC	DBHDS submitted the following documents: MRC Data Report Q4 2020, MRC Data Report Q1 2021, MRC Data Report Q3 2021, MRC Data Report Q3 2021 Final 5.27.21.	X		This study verified that DBHDS achieved the requirements for this Compliance Indicator of 33.20. See Attachment 25.
33.20	MRC tracks implementation of QI initiatives	Internal to the MRT, excel spreads record the preliminary raw data. It is then transformed at intervals into reports for review by the MRC and Commissioner. DBHDS submitted the following documents: MRC Data Report Q4 2020, MRC Data Report Q1 2021, MRC Data Report Q3 2021, MRC Data Report Q3 2021 Final 5.27.21. MRC discusses the results documented in these quarterly reports. MRC minutes reflect the MRC	X		This study verified that DBHDS achieved the requirements for this Compliance Indicator of 33.20. See Attachment 26.

		communication/ review of this information.			
33.21	DBHDS disseminates the Quality Management Annual Report to stakeholders	Submitted was the "Developmental Disabilities Quality Management Plan Annual Report and Evaluation: completed October 2020.	**X**		Date of release: 3/31/21
33.21	Quality Management Annual Report contains information related to QI initiatives, including any alerts or identified resources that promote QI consistent with indicators. V.8.4.f ("Through the Quality Management Annual Report, the QIC ensures that providers, case managers, and other stakeholders are informed of any QI initiatives approved for implementation as the result of trend analysis based on information from investigations of deaths")	Submitted was the 'DBHDS DD Quality Management Plan FY 2020 and Appendices 3.31.2020.	X		This study verified that DBHDS achieved the requirements for this Compliance Indicator of 33.20. See Attachment 27.

Summary Bullets:

Advances

MRC meets twice monthly

Names of attendees with titles and department/institution affiliation continue to be documented as part of the MRC minutes.

Attendance at the MRC meetings reflects a robust multidisciplinary approach.

Data collection reflects increased accuracy and completeness.

Timely monitoring and inventory of received documents for review at periodic intervals allows for an efficient process in completing the document review process in preparation for the MRC.

A standardized format for mortality reviews continues to be utilized in providing essential information during MRC meetings.

Both Chair and Co-Chair of the MRC have clinical backgrounds.

An independent practitioner continues to participate in the MRC.

The MRC charter is followed, ensuring a formal mortality review process.

Database management continues to ensure the integrity and completeness of the data.

The MRC tracking system for pending information includes a monitoring process until data collection or recommendation implementation closure.

The Special Investigations Unit of the Office of Licensing has been able to provide information allowing improved categorization of deaths as Expected/Unexpected, potentially preventable, and cause of death with reduction of the number of cases with an unknown cause of death, and whether maltreatment was a concern. This process has allowed the MRC to categorize potentially preventable deaths more accurately.

The ability to access death certificates and medical records from a variety of settings has improved the quality and completeness of information reviewed by the MRC. This has led to improved data collection quality, consistency, and completeness.

Challenges:

The MRC had been able to complete the MRC process within 90 days of death until April 2021. Since then, the submitted information indicates the 90-day threshold has been consistently missed through the last MRC reviewed (7/22/21).

A review /expansion of the 4 categories of potentially preventable death would benefit the MRC in developing QIIs and systems recommendations.

Sudden cardiac death remains an area needing further review to reduce the number of deaths assigned to this category. With the improved medical record data collection, reviewing comorbidities,

medications, etc. may assist in defining further subcategories that can then be reviewed for potential QIIs.

Cancer deaths remained a significant percentage of deaths. A review of whether the individuals reviewed completed preventive tests and procedures according to national standards would allow the MRC to determine if preventive care is being practiced in the waiver population.

Recommendations

Sudden cardiac deaths remain a category of death which needs further review, as this category is often based on the assumed cause of death being cardiac. It may be advantageous to track significant comorbid conditions or medication use to begin to shed light on the many potential causes in this category. With the ability to obtain hospital, emergency department, and physician office records, this may be an area of great promise in developing new QIIs.

Timely completion of mortality reviews within 90 days occurred from August 2020 to March 2021, but this threshold was not able to be sustained thereafter. Development of back up processes (such as cross training with other staff in DBHDS) for the timeliness of reviews is indicated to ensure the review process is sustainable and remains robust despite unforeseen administrative challenges.

Concerning quality improvement initiatives, it was noted that one of the initiatives, the tracking of 911 protocols, was carried forward to the following year as one of the four QIIs. Generally, follow through in successive years indicates that the obtained information and hopefully improved success is important, but should not detract from developing 4 new initiatives per year. There are numerous clinical opportunities to explore improvement, and there were several more that the MRC were working on (care giver stress, frailty index). If one counted follow up to established QIIs as one of the significant 4 presented, and this continues for several years, this would reduce the opportunity to focus on several other new topics during this time period.

Follow through QIIs are important, for they provide closure and, depending on the initiative, a multiple year focus provides compelling evidence of the impact. These should be categorized as follow-throughs to prior QIIs and are no less important in providing clinical information useful to the MRC, DBHDS, and the providers.

Several deaths were due to cancer. Given the increasing numbers of cancer deaths over time, there is need to track and encourage preventive care according to national standards.

It was noted in the MRC Annual Mortality Report that 354 deaths were reviewed. In a more recent comparable time period, there were listed 88 names of individuals in the waiver management system that had death certificates. However, 87 of these were dismissed, as they were due to having never received services due to being on a waiting list, or database entry errors, etc. Several steps were taken in each case to confirm they were not deaths in the waiver system. However, given that an additional 24% of cases had to be researched and dismissed, this was obviously a large drain of time and talent from the MRT. It would be of benefit to begin to review these entries in the waiver system so that the numbers for which this occurs begins to decrease.

Attachment 1

Documents submitted during prior review periods as reference/background information for this review:

Mortality Review Committee meeting minutes 2015: 2/11/15, 2/24/15, 3/11/15, 4/15/15, 4/17/15(2), 5/27/15, 6/10/15, 6/29/15, 7/10/15, 7/22/15, 10/14/15, 11/23/15, 12/2/15, 12/9/15, and 12/29/15.

2016: 1/27/16, 2/10/16, 3/9/16, 3/28/16, 6/8/16, 6/22/16, 6/30/16, 7/7/16, 7/13/16, 8/10/16, 8/24/16, 9/14/16, 9/21/16, 10/12/16, 11/9/16, 12/5/16, 12/9/16, 12/14/16, and 12/21/16.

2017: 1/11/17, 1/18/17, 2/15/17, 3/8/17. 3/22/17, 4/18/17, 4/26/17, 5/10/17, 5/24/17, 6/7/17, 6/14/17, 6/28/17, 7/19/17, 7/26/17, 8/9/17, 8/17/17, 8/23/17, 9/13/17, and 9/27/17, 10/25/17, 11/08/17, 11/27/17, 12/13/17, 12/27/17.

2018: (01/08/18), 01/10/18, 01/24/18, 02/01/18, 02/14/18, 02/22/18, 03/01/18, 03/08/18, 03/15/18, 03/29/18, 04/12/18, 04/26/18, 05/03/18, 05/10/18. 05/17/18, 05/24/18, 05/31/18, 06/07/18, 06/21/18, 06/28/18, 07/19/18, 07/26/18, 08/02/18, 08/09/18, 08/16/18, 08/23/18, and 08/30/18. 10/18/18, 10/25/18, 11/15/18, 11/29/18, 12/13/18.

2019: 01/03/19, 01/17/19, 01/31/19, 02/14/19, 02/28/19, 03/14/19, 03/28/19, 04/04/19, 04/18/19, 05/02/19, 05/23/19, 06/13/19, 06/27/19, 07/11/19, 07/25/19, 08/08/19, 08/22/19.

2020: 09/12/19, 09/26/19, 10/10/19, 10/24/19, 11/07/19, 11/21/19, 12/12/19, 01/09/20, 01/23/20, 02/13/20, 02/27/20, 03/12/20, 03/26/20, 04/09/20, 04/23/20, 05/14/20, 05/28/20, 06/11/20. 06/25/20, 07/09/20, 07/23/20

For the above listed meeting minutes, the MRPF reviews (Mortality Review Presentation Forms) for individuals discussed at these meetings.

2016 Mortality Tracker

2017 SFY Mortality Tracker (as of October 2017)

Draft Community DD Mortality Review Worksheet

'Mortality Among Individuals with a Developmental Disability: DBHDS Annual Mortality Report for January 1, 2015 –June 30, 2016'

Departmental Instruction 315 (QM)13 Reporting and Reviewing Deaths (draft)

Mortality Review Committee Operating Procedures 2017

Responses to Recommendations from the Independent Reviewer Report to the Court 12-23-16

Mortality Review Committee Membership/Participation (undated)

Numbered Recommendation Status Tracker

Mortality Review Committee tracking 3/15/17

Mortality Review Committee Interventions to Address Concerns

Form letter to Office of Vital Records for copy of death certificate (draft)

Form letter to provider organization requesting specific documents for review (draft)

DBHDS ID/DD Mortality 2013 Annual Report (May 2014 Draft)

DBHDS 2014 Annual Mortality Report (August 2015 draft): 'Mortality Among Individuals with an Intellectual Disability'

DBHDS Mortality Review Letter to Medical Practitioners (October 2015): "Reminding Medical Practitioners of High-Risk Conditions"

Mortality Review Committee data tracking documents: 2014 Mortality Tracker, 2015 Mortality Tracker, and 2016 Mortality Tracker (to 6/30/16)

Action Tracking Report FY 18 (in testing): Mortality Review Committee Action Tracking Report July-Sept 2017

DBHDS Instruction (July 2016 Draft): Mortality Review

Mortality Review Committee: Master Document Posting Process (undated)

Copy of Master Schedule July 2017 (in testing): MRC Master Document Posting Schedule (MDPS) Posting Period July 2017; Date Master Schedule Posted August 2017

Mortality Review Presentation Form (Final) Form MRC #001, 08/11/17

MRC Master Document Posting Schedule (MDPS) with drop downs

DI (Department Instruction) 315 Reporting and Reviewing Deaths. Draft. Field Review 10/3/17: DI 315 (QM) 13 Attachment B: (Name of Facility) Mortality Review Worksheet

MRC Meeting Minutes Shell 10/16/17

Office of Licensing DBHDS: ID/DD Death Mortality Review Committee Required documents/reviews

Safety and Quality Alerts of the Office of Integrated Health Services: Recognizing Constipation, Type II Diabetes, Type I Diabetes, Sepsis Awareness, Scalding, Preventing Falls, Breast Cancer Screening, Aspiration Pneumonia – Critical Risk, 5/19/17 Drug Recall Alert

Mortality Review Committee: Quality Improvement Plan: CY 2017

Recommendations Status 3/14/17

Quality Improvement Committee Meeting Minutes 7/6/17

2017 Progress Report: Office of Integrated health

Training Data (Skin Integrity Training)

MRC: Action tracking Log: Sept 2017 - Dec 2018 Plus Outstanding Recommendations from Previous Tracker

Excerpt from the Office of Integrative Health Annual Report: Data ending April 30, 2017 report published June 2017

Virginia DBHDS Annual Mortality Report SFY 2017: Mortality Among Individuals with a Developmental Disability

Power Point Presentation: Death Certificates: Quarterly Data Presentation "Incorporating VDH Death Certificates onto the MRC Tracker" August 2018, Virginia DBHDS

Standard Operating Procedures for the DBHDS DD Mortality Review Committee (prepared 6/12/18)

FY 2017 Mortality Discrepancy file

2018 SFY Mortality Discrepancy file

Mortality Review Tracking Tool FY18

Mortality Review Tracking Tool Oct 2017-Feb 2018

Mortality Review Presentation Form

MRC Samples of Data Warehouse Reports: DW-0064 Incidents, DW-0055 Mortality Report Detail, DW-0025 Death and Serious Injury reporting Time Detail

Action Tracking Log Sept 2017- Dec 2018 Plus Outstanding Recommendations from Previous Tracker

Action Tracking Log Oct 2017 – present.

13th Review MRC Health Alerts Developed as a Result of MRC Recommendations: Sickle Cell, Aspiration pneumonia, congestive heart failure, stroke,

Health Alerts Developed as a Result of MRC Recommendations (Alerts from Oct 2017 – 8/8/18)

Health Alerts Developed as a Result of MRC Recommendations (Newsletter Topics from Oct 2017 – present [September 2018]}

Newsletter (Virginia DBHDS) "Health Trends" for the following months with featured health alert/focused topics:

October 2017: Bowels: Constipation, C-diff, and Obstruction

November 2017: Diabetes management

December 2017: Aspiration

January 2018: Sickle Cell Anemia, Winter and Extreme Cold Preparation

February 2018: Seizures

March 2018: Congestive Heart Failure, Depression and Suicide, Medication Management

April 2018: Urinary Tract Infections, Safety for Individuals with Autism

May 2018: Stroke, Transportation Safety for individuals in Wheelchairs

June 2018: Choking, Behavioral Changes and Underlying Medical Issues

September 2018: Pica

Power Point Presentation: Tracking Health and Safety Alert Views: Mortality Review Committee, August 30, 2018, Virginia DBHDS

MRC Master Document Posting Schedules (MDPS) for each month from September 2019 - July 2020

"Mortality Review Office Procedures" Draft June 2020

"Mortality Review Office Procedure" Draft July 2020

"Investigations: Appendix C: DD Death Investigations Revised for Indicators 4/1/2020

"Mortality Review Form" Blank copy

"Office of licensing Protocols Investigations," revised for indicators 4/1/20

Mortality Review Committee Charter: September 2019, final Draft FY21 09082020

Potential Unreported Deaths log for each month: July 2019-June 2020

MRC Data Report Final Drafts: Q3 2020, Q4 2020

FY20 eMRF Database Spreadsheet Column titles

MRC Action Tracking Log 09.01.19 through 7.23.20

MRC DOJ Indicators July 2020

Quarterly Report to the Commissioner SFY 2020, Quarters 3 & 4

Mortality Review Committee SFY 2020 June QIC Report/ Annual Mortality Review Report SFY 2019

Annual Mortality Report SFY 2019

Mortality Review Committee Member Orientation March 26, 2020

MRC member orientation: 'Quality Improvement: Putting the Pieces Together' March 26, 2020'

Copy of DBHDS MRC Confidentiality Agreement signed (for 16 members)

MRC Orientation Attendance roster 3/26/20

DBHDS Departmental Instruction 315(QM)13

MRC process map

Office of Licensing- DBHDS: Mortality Review Submission Checklist for Required Records

DW-0080a incident Management Reports 9/1/19-10/4/19, 10/1/19-11/5/19, 11/1/19-11/30/19, 12/1/19-12/31/19, 1/1/20-2/5/20, 2/1/20-3/2/20, 3/1/20-3/31/20, 4/1/20-4/30/20, 5/1/20-5/31/20, 6/1/20-6/3/20, 7/1/20-7/31/20

DW-0080a – Incident Management Report Sample.xls

DW-0080a Incident Management Report 1.1.20-8.31.20

DD Deaths.late.docx (Jan 1,2020-Aug 31,2020)

'A Guidance Document for Department of Behavioral health and Developmental Services Incident Management' (Revised 5/22/20)

DBHDS Memorandum to DBHD Licensed Providers Re: Guidance on Incident Reporting Requirements 8/22/20

DD Death SIU Tracking SIU Tracking Spreadsheet 1.1.20-8.31.20.xlsx

QIC meeting information: 9-5-2019 Approved QIC Minutes, QIC Meeting September 2019 Agenda, QIC Meeting December 2019 Agenda, Dec 2019 MRC QIC Report FY19, 12-5-2019 Approved QIC Minutes, Mortality Review Committee (MRC) QIC Report Final March 5, 2020, QIC Meeting March 2020 Agenda, 3-5-2020 Approved QIC Minutes, Draft 6-30-2020 QIC Minutes, QIC Meeting June 2020 Agenda, June 2020 DBHDS MRC Report to QIC

ATTACHMENT 2 (C1 #33.03.a-d)

The document 'MRC Orientation Attendees August 1, 2020- July 31, 2021' provided training for attendees new to the MRC during the 19th study period. See Attachment C for details. There were 2 members who had not completed training prior to participation in the MRC. The following was noted, date of member's training, along with review of date of first attendance at MRC to determine if training occurred prior to participation in MRC: BD 11/12/20, date of first attendance 11/19/20, AE 11/12/20, date of first attendance 11/19/20, JK 11/12/20, date of first attendance 11/19/20, MO 11/12/20, date of first attendance none, KP 11/12/20, date of first attendance 11/19/20, BW 3/8/21, date of first attendance 3/11/21, KP 7/1/21, date of first attendance 6/24/21, JS 7/1/21, date of first attendance 6/24/21, but information was provided that they were not members but observers at time and had completed a confidentiality statement. BA 8/3/21, date of first attendance none, ZK 8/3/21, date of first attendance none

ATTACHMENT 3 (C1 #33.04)

This study verified that DBHDS achieved the requirements for Compliance Indicator 33.04. This determination was made based on a review of MRC meeting minutes and MRC Meeting Minutes Attachments. Dates of MRC minutes and attachments. Dates of MRC meetings: 8/13/20, 8/27/20, 9/10/20, 9/24/20, 10/8/20, 10/22/20, 11/5/20, 11/19/20, 12/3/20, 12/17/20, 1/14/21, 1/28/21, 2/11/21, 2/25/21, 3/11/21, 3/25/21, 4/8/21, 4/22/21, 5/13/21, 5/27/21, 6/10/21, 6/24/21, 7/8/21, and 7/22/21.

ATTACHMENT 4 (C1 #33.05)

This review verified that the 'Mortality Review Committee Action Tracking Log' identified recommendations from 8/13/20 - 6/24/21 and that the MRC tracked recommendations through closure.

Mortality Review Committee Action Tracking Log' is source of the following information: Submitted for individuals needing follow up of recommendations from 8/13/20- 6/24/21 by DBHDS ID #: 8/13/20 #264825, #601998, 8/27/20 #282856 1 of 3 and 2 of 3 and 3 of 3, #1353811 1 of 2 and 2 of 2, 9/10/20 #129961 1 of 2 and 2 of 2 , 9/24/20 #106845 1 of 2 and 2 of 2, #208524 1of 2 and 2 of 2,

#527709, #1359458, #1036539 1 of 3 and 2 of 3, and 3 of 3 , #11578 1 of 2 and 2 of 2, #75565, 10/8/20 #169115, 12/17/20 #427180, 11/19/20 #479747, 12/3/20 #675740 1 of 3 and 2 of 3 and 3 of 3,, 12/17/20 #1580221, #712714 1 of 2 and 2 of 2, #1708441, 1/14/21 #1714175 1 of 1 and 2 of 2, #362483, 3489147, 1/14/21 #94530, 1/28/21 #551513, 1/28/21 #416910, 2/11/21 #1136592, #1291234, #118971 1 of 2 and 2 of 2, 2/25/21 #388272, 3/11/21 #28, #36554, #1513104, 3/25/21 #476880, 4/8/21 #672421, #14538, #251171, 4/22/21 #601054, #273001, 5/13/21 #134244, #317858 1 of 1 and 2 of 2, #474073, #676944, #187488, 5/27/21 #444124, 6/10/21 #134971 1 of 2 and 2 of 2, 6/24/21 #250360 1of 2 and 2 of 2.

ATTACHMENT 5 (CI #33.05)

MRC meeting minutes on the following dates included a narrative section providing updates of QI initiatives:

10/22/20, 12/3/20, 2/25/21, 3/11/21, 3/22/21, 5/13/21, 5/27/21, 6/10/21. Details of the analysis/summary tracking were shared with the MRC. Provided here are the MRC dates for the MRC meeting minutes which tracked the QII and shared with the MRC members.

When there was implementation of QI initiatives, tracking was reflected in the minutes of the MRC at periodic intervals:

The MRC meeting minutes of 10/22/20 indicated a draft report of the 2020 MRC Annual report was to be emailed to the committee members for review. This included QII initiatives at various stages of approval and implementation.

The MRC meeting minutes of 12/3/20 documented that the FY 2021 Q Quarterly Data Report was reviewed with the MRC (including robust discussion by MRC members).

The MRC meeting minutes of 2/25/21 included documentation of the Quarterly Data Review for Q2 FY2021 with discussion by committee members.

At the 3/11/21 MRC meeting, minutes indicated a review of previously approved and implemented QII in addition to two proposed QIIs to be presented to the QIC on 3/22/21.

The MRC meeting minutes of 5/13/21 included documentation of review of the quarterly data report for Q3 FY 2021. There was also review of two possible QIIs for presentation to the QIC (subject matter concerned COVID 19 focus, and separately SIS levels).

The MRC meeting minutes of 5/27/21 documented a discussion of potential QIIS concerning increasing vaccination rates, as well as knowledge deficits for COVID 10.

The MRC meeting minutes of 6/10/21 reviewed ensuring QII standards, measurement and two QII that were previously proposed, and timelines were to be added prior to presentation to the QIC.

The MRC meeting minutes of 7/22/21 reviewed a prior QII proposal concerning caregiver burnout

ATTACHEMENT 6 (C1 #33.06)

This study verified that DBHDS achieved the requirements for this Compliance Indicator 33.06.

The MRC Master Document Posting Schedule (MDPS) provided this data which was reviewed. See Attachment for details.

The MRC Master Document Posting Schedule (MDPS) was provided for August 2020 through July 2021. For each of the deaths, the date was recorded when the Office of Licensing submitted their investigation to the MRO. The following are the results of the analysis of this information. August 2020: 23/23 applicable deaths reviewed, (two additional deaths were not reviewed by the OL for the MRC – one death not receiving services. And one death at SWVAMHI) which was not licensed by DBHDS. September 2020, 24/24 applicable deaths reviewed. (One additional death did not have a DD diagnosis and tracked through the 'Discrepancy Log', although a licensing report was submitted.) October 2020: 27/27 applicable deaths reviewed. November 2020, 34/34 applicable deaths reviewed. December 2020, 35/35 applicable deaths reviewed. January 2021, 60/60 applicable cases (one additional death reported was not receiving services and 2 deaths were in state facilities and not licensed by DBGDS), February 2021, 37/37 applicable deaths (one death from a state facility not under DBHDS licensing, and 3 deaths not receiving DBHDS services and placed on Discrepancy log. one other death not applicable), March 2021, 28/28 applicable deaths reviewed (one death occurred when not receiving services), April 2021, 24/24 applicable deaths (2 deaths were at state facilities not under DBHDS licensing), May 2021, 44/44 applicable deaths reviewed (One additional death was at a state facility and one death was not receiving DBHDS DD services). June 2021 deaths were being reported at a future MRC.

ATTACHMENT 7 (C1 #33.09)

The following represents the completion per month of the OL investigation within 45 business days: August 2020-23/23 (one death review was from a state facility not under DBHDS licensing), Sept 2020:24/24, October 2020: 27/27, November 2020: 33/34, December 2021: 35/35, Jan 2021 60/60, Feb 2021 37/37, March 2021 28/28, April 2021: 24/24, May 2021 44/44, June 2021: 19/25 with 6 pending, The 'MRC Data report Q2 2021' recorded timely compliance (100%) by the OL for Q1 FY21. The 'MRC Data report Q3 2021' recorded timely compliance (99%) by the OL for Q2 FY21.

ATTACHEMENT 8 N (C1 #33.10a)

This study verified that DBHDS achieved the requirements for this Compliance Indicator of 33.10a

Step 1: As evidence of this step, a sample of queries by SIU in January 2021 was submitted with the following dates of report query: 1/8/21, 1/15/21, 1/22/21, 1/29/21, and 2/5/21.

Step 2: Evidence of this communication/ information includes emails to the MROPC from the SIU on the following dates: 8/5/20, 9/4/20, 10/5/20, 11/5/20, 12/4/20, 1/6/21, 2/5/21, 3/5/21, 4/2/21, 5/6/21, 5/28/21, 7/6/21, and 8/5/21.

Step 3: Information was provided by the MROPC for dates of query for I/DD deaths which occurred in a facility were submitted as evidence of this step. The information listed the following: July 2020 - 3 queries, August 2020 - 2 queries, September 2020 - 5 queries, October 2020 – 3 queries, November 2020 - 1 query, December 2020 - 1 query, January 2021 -1 query, February 2021 - 2 queries, March 2021 - 1 query, April 2021 - 1 query, May 2021 - 1 query, June 2021 - 1 query, July 2021 -2 queries.

ATTACHMENT 9 (C1#33.11)

The clinical reviewer completed the following clinical mortality reviews and placed the information in the electronic Mortality Review Forms (eMRF) for the following MRC meetings: 8/13/20 MRC 20 eMRFs, 8/27/20 MRC 17 eMRFs, 9/10/20 12 eMRFs, 9/24/20 11 eMRFs, 10/8/20 MRC 17 eMRFs, 10/22/20 MRC 10 eMRFs, 11/5/20 MRC 13 eMRFs, 11/19/20 MRC 17 eMRFs, 12/3/20 MRC 9 eMRFs. 12/17/20 MRC 9 e MRFs, 1/14/21 MRC 20 e MRFs, 1/28/21 MRC 14 eMRFs, 2/11/21 MRC 21 eMRFs, 2/25 MRC 14 eMRFs, 3/11/21 MRC 19 eMRFs, 3/25/21 MRC 19 eMRFs, 4/8/21 MRC 21 eMRFs, 4/22/21 MRC 17 eMRFs, 5/13/21 MRC 23 eMRFs, 5/27/21 MRC 9 eMRFs, 6/10/21 MRC 14 eMRFs, 6/24/21 MRC 10 eMRFs, 7/8/21 MRC 8 eMRFs, 7/22/21 MRC 7 eMRFs. Each of the 351 eMRFs was reviewed for completeness and was found to have all components completed that were applicable to the death. This information was discussed at the time of the MRC. The date of completion of each of the eMRFs is posted in the Master Document Posting Schedule (MDPS).

ATTACHMENT 10 (C1#33.11)

100% of the deaths were categorized at the MRC into Tier 1 or Tier 2. For Tier 1, numbers reflect both new Tier1 cases and pending Tier1 cases reviewed at subsequent meetings as each presentation used the eMRF information for discussion and reference. 8/13/20 MRC 5 Tier 1 reviews & 17 Tier 2 reviews, 8/27/20 4 Tier 1 reviews & 13 Tier 2 reviews, 9/10/20 3 Tier 1 reviews & 9 Tier 2 reviews, 9/24/20 7 Tier 1 reviews & 7 Tier 2 reviews, 10/8/20 MRC 8 Tier 1 reviews, & 9 Tier 2 reviews, 10/22/20 MRC 6 Tier 1 reviews & 9 Tier 2 reviews, 11/5/20 MRC 8 Tier 1 reviews & 9 Tier 2 reviews, 11/19/20 MRC 12 Tier reviews & 7 Tier 2 reviews, 12/3/20 MRC 4 Tier 1 reviews & 6 Tier 2 reviews, 12/17/20 8 Tier 1 reviews & 4 Tier 2 reviews, 1/14/21 MRC 10 Tier 1 reviews & 11 Tier 2 reviews, 1/28/21 MRC 8 Tier 1 reviews & 9 Tier 2 reviews, 2/11/21 MRC 10 Tier reviews & 13 Tier 2 reviews, 2/25/21 MRC 9 Tier 1 reviews & 8 Tier 2 reviews, 3/11/21 MRC 12 Tier 1 reviews & 10 Tier 2 reviews, 3/25/21 MRC 11 Tier 1 reviews & 9 Tier 2 reviews, 4/8/21 MRC 9 Tier 1 reviews & 15 Tier 2 reviews, 4/22/21 MRC 8 Tier 1 reviews & 9 Tier 2 reviews, 5/13/21 MRC 6 Tier1 reviews &17 Tier 2 reviews, 5/27/21 6 Tier 1 reviews & 4 Tier reviews, 6/10/21 MRC 8 Tier 1 reviews & 6 Tier 2 reviews, 6/24/21 MRC 3 Tier 1 reviews & 7 Tier 2 reviews, 7/8/21 MRC 6 Tier 1 reviews & 4 Tier 2 reviews, 7/22/21 MRC 7 Tier 1 reviews & 3 Tier 2 reviews

ATTACHMENT 11 (C1#33.12)

The following lists per month the number of potential cases that were researched and found not to be unreported deaths in the DBHDS system (several did not have services at time of death (waiting list only), some were data entry errors, etc.): July 2020 – 9 cases, August 2020- 8 cases, September 2020 -6 cases, October 2020 – 6 cases, November 2020 - 7 cases, December 2020- 6 cases, January 2021 – 6 cases, February 2021 – 9 cases, March 2021 – 3 cases, April 2021 – 10 cases, May 2021 – 7 cases, June 2021 - 10 cases. For the 12 months listed, this totaled 88 cases.

From Feb 021 Potential Unreported deaths, there was one death that was found to be unreported. This death was review by the MRC on 5/13/21. From the time period August2020 through July 2021, this was the only unreported death and was captured by this process.

An additional case (DBHDS ID# 265250) was reported late (DOD 4/15/20 and reported 7/15/20), but the process to identify this case could not be determined as it was outside of the documentation timeframe. The MRC did review the case 9/10/20. The licensing report was available for the review, and there was no CAP issued, nor evidence of maltreatment/OHR violation.

ATTACHMENT 12 (C133.12)

For the one death reported late/unreported DBHDS ID# 9999021, licensing investigation was completed 4/29/21 and reviewed by the MRC 5/13/21.

The circumstances of the unreported death were recorded on the eMRF as follows: “Provider was not required to report …death since … no longer receiving a licensed service ~ 435 days prior to death. (Discharged from DBHDS licensed group home). Because this individual did receive licensed services within 90 days form DoD, the MRC was required to review the case.

ATTACHMENT 13 (C1# 33.12)

From the one unreported case discovered by this additional process from the time period August 2020 through July 2021, according to the eMRF, there was no CAP issued and no evidence of maltreatment nor OHR violation. Death was considered expected and not preventable.

An additional case (DBHDS ID# 265250 was reported late (DOD 4/15/20 and reported 7/15/20), but the process to identify this case could not be determined as it was outside of the documentation timeframe. The MRC did review the case 9/10/20. The licensing report was available for the review, and there was no CAP issued, nor evidence of maltreatment/OHR violation.

ATTTACHMENT 14 (C1#33.13) DBHDS data

The 'MRC Data Report Q4 2020' recorded 37 unexpected deaths. 90-day review compliance for all deaths was 91.9%. The 'MRC Data Report Q1 FY2021' recorded 49 unexpected deaths. 90-day review compliance for all deaths was 97.1%. The 'MRC Data Report Q2 FY2021' recorded 36 unexpected deaths. 90-day review compliance for all deaths was 100%. The 'MRC Data Report Q3 FY2021 Report' recorded 62 unexpected deaths (39% due to COVID 19). 90-day review compliance was 93.4%.

ATTACHMENT 15 (C1 #33.13) factual verification data

Beginning with the 4/22/21 MRC meeting, the number of unexplained/unexpected deaths with completed MRC review within 90 days decreased. The following information was obtained from review of the MRC meeting minutes:

MRC 4/22/21 Unexpected deaths completed within 90 days - 2 cases, >90 days - 9 cases, MRC 5/13/21 unexpected deaths completed within 90 days - 1 case, >90 days 12 cases; MRC 5/27/21 unexpected deaths completed within 90 days - 0 cases, >90 days - 6 cases; MRC 6/10/21 unexpected deaths completed within 90 days - 0 cases, >90 days - 7 cases, MRC 6/24/21 unexpected deaths completed within 90 days - 0 cases, >90 days - 5 cases, MRC 7/8/21 unexpected deaths completed within 90 days - 0 cases, >90 days - 3 cases, MRC 7/22/21 unexpected deaths completed within 90 days - 0 cases, >90 days - 2 cases. In summary, from the MRC 4/22/21 through 7/22/21, 3 of 47 unexpected deaths were completed within 90 days. For the year, there were 193 unexpected deaths. Of these 134 were completed within 90 days (69%). Until the 4/22/21 MRC, the system met compliance. However, as of the 7/22/21 MRC, the process has not corrected.

ATTACHMENT 16 (C1#33.14a)

The MRC charter defined medical records as 'including health care provider and nursing notes for three months preceding death." For physician notes, this was included in the eMRF category 'medical records. Availability of medical records occurred in 262/315 (83%) cases. For 36 cases, medical records were considered not applicable. However, given the charter definition of medical records, it was not clear the percentage of cases which had physician notes and the percentage of cases which had nurses' notes.

Further, there was another eMRF category of documents entitled progress notes available for 342/349 (98%) cases. For 2 cases, progress notes were considered not applicable. For 7 cases, there was documentation of unavailability. It was not clear from the documentation the source of the 'progress notes': When the MRT reviewer was interviewed, he confirmed the progress notes were written by QIDPs, case managers, service coordinators, and residential staff, but rarely nurses (in some service settings or settings in which some services were provided, nurses notes did not occur.) Nurses note availability was not separately documented in either the 'medical records' category or the 'progress notes' category. As a result, lack of availability of nurses' notes were not specifically tracked.

From the above information, the percentage of physician notes available or not available was not able to be determined. From the above information, the percentage of nurses notes available or not available was not able to be determined.

CHRIS (Computerized Human Rights Information System) Serious Injury Reports were available for 336/344 (97.6%) of cases. For 7, these reports were considered not applicable for the remainder there was notation of unavailability.

ATTACHMENT 17 (C1#33.14a)

ISPs were available for 338/344 (98%) applicable cases reviewed. For 7 cases, this document was considered not applicable. For the remainder, there was notation of unavailability.

Physical exam records were available for 210/348 applicable cases reviewed. For 3 cases, this document was considered not applicable. For the remainder, there was notation of unavailability.

Death certificates were available for 333/350 (95%) applicable cases. For one case, this document was considered not applicable. For the remainder, there was notation of unavailability.

Maltreatment was documented in 31 (8.8%) cases reviewed from 8/13/20 through 7/22/21.

ATTACHMENT 18 (C1#33.14b)

There were 23 interviews completed during the reviews of 8/1320 through 7/22/21. These were often associated with cases initially determined as pending based on deliberations of the MRC and were a source of information used to close the case at a subsequent MRC meeting.

ATTACHMENT 19 (C1#33.15)

Submitted were several reports providing evidence of reporting periodic information from the MRC to the Commissioner. These included the following MRC Quarterly Reports to the Commissioner: "A Report on Deliberations and Findings During Quarters 3 & 4 of State Fiscal Year 2020," "A Report on Deliberations and Findings During Quarter 1 of State Fiscal Year 2021," "A Report on Deliberations and Findings During Quarter 2 of State Fiscal Year 2021," and "A Report on Deliberations and Findings during Quarter 3 of State Fiscal Year 2021". Content in each report included cases reviewed, causes of death, unexpected deaths, potentially preventable deaths, 90-day compliance monitoring, MRC recommendations (focus on providers) and recommendations to the QIC. Additionally, for the 2nd Quarter report, an update was provided concerning attendance compliance monitoring, and 45-day document collection compliance monitoring. Additionally, for the 3rd Quarter report, there was additional reporting on Attendance Compliance Monitoring, 45-Day Documents collection compliance monitoring, COVID-19 deaths, and MRC actions for potentially preventable community deaths.

ATTACHMENT 20 (C1#33.16)

Individual provider concerns are tracked through the MRC Action Tracking Log FY21 to resolution. Additionally, concerns identified at the individual service level were listed in the MRC Quarterly Report(s) to the Commissioner. From this information, potentially preventable deaths were followed, and recommendations made by the committee.

The MRC identified 40 potentially preventable deaths between August 1, 2020, through July 31, 2021. Whereas in SFY 2020, the MRC identified only 17 such deaths.

At the systemic level, the Virginia DBHDS SFY 2020 Annual Mortality Report documented 354 deaths, leading causes of death were: sudden cardiac death (43 deaths 12%) sepsis (40 deaths, 11%) cancer (34 deaths, 10%) and heart disease (28 deaths, 8%). Unknown cause of death 16 (5%). This is the lowest percentage of deaths since MRC inception in 2012. Determining the cause of death accurately was the first step in initiating a QI to reduce mortality. Subsequently, several QIIs have been implemented. The SFY20 MFC Annual Report provided 4 recommendations based on data collection through the MRC process: 1. In SFY2021, DBHDS should implement a quality improvement initiative to increase the number of mortality review cases in which 911 protocol was followed to greater than 60%. DBHDS should track the impact on the DBHDS DD MRC of the legislation allowing the MRC greater access to information and records. 3. Increase the number of death certificates available for DBHDS DD MRC to >90%. 4. Evaluate underlying cause and conditions that lead to increase in sepsis deaths in this population.

A Power Point presentation, provided a summary of MRC in this area for the QIIs recommended to the QIC for the year reviewed in this report: “MRC Proposed QIIs to the QIC August 1, 2020, through July 31, 2021”

ATTACHMENT 21 (C1#33.17i-v)

The SFY20 MRC Annual Report included the following information:

i.This report documents 354 deaths, leading causes of death were: sudden cardiac death (43 deaths 12%) sepsis (40 deaths, 11%) cancer (34 deaths, 10%) and heart disease (28 deaths, 8%). Unknown cause of death 16 (5%) This is the lowest percentage of deaths since MRC inception in 2012.

ii. This was documented in Table 4, as 19.22 (per 1,000 population).

iii. Crude mortality rate was provided for congregate living (34.9 deaths per 1,000 population) and independent living (10.2 deaths per 1,000 population.)

iv. This information is provided in Table 4 by decade of life from age 31 to 80. Prior to age 31, there were two age groups, 0-17 and 18-30. Deaths after age 80 were placed in one age group ‘81 or greater’

iv. Table 5 provides the data for the crude mortality rates by gender The crude mortality rate for females was 21.5 per 1,000 population. For males the crude mortality rate was 17.76.

iv. Table 6 reviewed the crude mortality rate by race. For white/Caucasian, the crude mortality rate was 21.29, for Black/African Americans it was 18.12, and for others it was 7.07%.

v. by age: “Between SFYs 2017 and 2020, the crude mortality rate among individuals on a DD Waiver increased for all age groups between 51 and 80. Compared to SFY 2019, the crude mortality rate among the DD Waiver population increased for all age ranges except among individuals between the ages of 18 and 30.” Figure 3 reviewed the crude mortality rate by age for SFY 2017-2020.

v. by gender: Table 5 and Figure 4 review the crude mortality rate gender and by fiscal year. Although males comprised the majority of deaths, in FY 2020, the crude mortality rate was lower than females, and improved slightly from FY 2019.

v. by race: The report records the crude mortality rate for both white and black/African American populations increased from FY 2019.

v. by residential settings and DBHDS facilities: The report included number of deaths for each category, and the percentage of total deaths according to each category for the following categories of residence: independent living, congregate living, community institutional living (non-state operated setting), state facility and unknown.

Each category was defined further for clarity of the category as to what type of living arrangement was included in each category.

The report documented the leading causes of death in those living independently were sudden cardiac death, cancer, heart disease, pneumonia and unknown. For those living in congregate settings, the leading causes of death were sepsis, sudden cardiac death, and failure to thrive/slow decline.

A crude mortality rate was calculated for those living in congregate living centers and independent settings. The crude mortality rate in congregate living settings was 34.9 and for independent living was 10.2. The crude mortality rate for those in congregate settings increased from 29 to 34.9. For those in independent living, the rate decreased from 11.6 to 10.2 deaths per 1000 population in SFY 2020.

v. by service program: DBHDS uses the Supports Intensity Scale to determine level of service and supports for each individual. There are 7 levels which reflect the various intensity of need of the individual and the services/supports required. Crude mortality rate was provided for each SIS level. The report indicated that from SFY 2019 to 2020, the crude mortality rate increased for individuals with SIS levels 2, 6 and 7, and decreased for those with SIS levels 1,3,4 and 5 in SYF 2020.

The highest crude mortality rate was for SIS level 6, and reflected those with the highest level of medical needs (an increase from a crude mortality rate of 65.4 in SFY 2019 to 76.2 in SFY 2020.) Level 7 is defined by behavioral services at a high intensity need level, which may include additional need for medical services. For individuals with SIS level 5, there was a decrease in mortality from 60.6 in SFY 2019 to 31.5 in SFY2020.

v. by cause of death: The report discussed the cause of death, further categorized by gender. For males, the leading causes were sudden cardiac death, sepsis, and heart disease. For females, the leading causes were cancer, cardiac death, sepsis, heart disease, and pneumonia.

ATTACHMENT 22 (C1#33.18)

The following excerpts provide evidence that the 'SFY 2020 Annual Mortality Report' documents recommendations for systemic QI initiatives from patterns of individual reviews or patterns that emerge from any aggregate examination of mortality data annually or twice annually:

"Recommendation 1: …The DBHDS DD MRC implemented a quality improvement initiative to improve providers' adherence to 911 protocols, for which the baseline data determined that an average of 30% of deaths where 911 was a factor, properly followed the correct protocol. In SFY 20212, DBHDS should implement a quality improvement initiative to increase the number of mortality review cases in which 911 protocol was followed to greater than 60%.

Recommendation 2: in the 2019 Annual Report, it was recommended that DBHDS should maintain an established target of less than10% of deaths reviewed to be classified as 'unknown' for the cause of death. … In 2020, SB482 was passed by the General Assembly to legislatively establish the Developmental Disabilities Mortality Review Committed, which provides greater access to information and records regarding an individual who death is being reviewed by the Committee from providers beyond those licensed by DBHDS. This legislation went into effect on July 1, 2020, and DBHDS should track the impact on the DBHDS DD MRC for determining the cause of death, to maintain the established target.

Recommendation 3: For SFY21, DBHDS should increase the number of death certificates available for DBHDS DD MRC review and establish a baseline for the number of I/DD individuals with a death certificate available for mortality review to >90%.

Recommendation 4: Death due to sepsis represented 11% of deaths in this study year. While sepsis, once it occurs, can often lead to mortality, there are a number of contributory illnesses that may benefit from early detection and intervention to prevent death. For SFY21, DBHDS should further evaluate underlying causes and conditions that lead to increase in sepsis deaths in this population."

The recommendations are reported annually in the DBHDS Annual Mortality Report.

ATTACHMENT 23 (C1#33.19 PART 1)

Recommendations from the MRC are listed in the FY20 Annual Mortality Report (see Attachment 22 above).

Additionally, the document entitled 'MRC proposed QIIs August 1, 2020 to July 31, 2021 lists the various proposed QIIs submitted to the QIC during this time period, which includes more recent progress in this area. This document provided more detail to the proposed QIIs, including whether the QIC approved the QII or not. The following excerpts reflect the MRC QIIs for the year presented to the QIC:

"Reduce the number of deaths due to sepsis in the DD population in the SFY 2021." This includes a detailed plan of 6 steps and a timeline with specific projected dates in accomplishing this plan. This was approved at the 9/21/20 QIC.

However, phase 2 of this plan (phase 2 was not defined in submitted document) was not approved by the QIC at the 12/14/20 QIC meeting.

A more detailed QII for reducing sepsis mortality was documented as "to increase awareness of the potential development of sepsis in I/DD individual by training and educating providers on early recognition of signs and symptoms, comorbid conditions, and risk factors – thereby decreasing the number of I/DD sepsis deaths by 1% per year." This QII was approved by the QIC at the 3/22/21 QIC meeting.

The MRC proposed the QII: "To decrease COVID-19 mortality rate for individuals on the I/DD waiver to <10% by SFY22 Q2 through enhancing vaccine rates, continued support for execution of infection control measures, and enhanced surveillance and early detection of COVID 19." This QII was approved by the QIC at the 6/28/21 QIC meeting.

The MRC proposed the following QI: "To reduce the crude mortality rate by 5 per 1000 deaths, each year for the next two years (SFY22 and SFY23) of individuals with IS level 6. In SFY20, the highest crude mortality rate on the waiver was SIS level 6." This QII was approved at the 6/28/21 QIC meeting.

ATTACHMENT 24 (C1#33.19 PART 2)

A document entitled 'MRC Proposed QIIs to the QIC August 1, 2020 through July 31, 2021' reviewed the QIIs proposed by the MRC and the QIIs approved by the QIC for the most recent available time period (which includes more recent information on ongoing recommendations and initiatives beyond the Annual Mortality Report. The 9/27/21 QIC minutes reflected discussion of an additional QII presented by the MRC. Entitled "Proposed Frailty QII".

The following MRC Quarterly Reports were provided to the Commissioner: 'MRC Quarterly Report to the Commissioner: Q3-4 FY20 Q1 FY21, Q2 FY21, Q3 FY21. When a recommendation is made to the QIC, this is recorded in this document in a section entitled "recommendations to the QIC'. The MRC Quarterly Report to the Commissioner Q3-4 FY20 reviewed the recommendation presented at the June 2020 QIC meeting, to reduce the deaths classified as unknown cause, by increasing the availability of death certificates. The MRC Quarterly Report to the Commissioner Q1 FY21, reviewed the September 2020 recommendation made to the QIC concerning the need to reduce the number of deaths due to sepsis in the DD population. The MRC Quarterly Report to the Commissioner Q2 FY21 had no updates on MRC recommendations to the QIC. The MRC Quarterly Report to the Commissioner Q3 FY21 which stated: "The MRC made one recommendation to the QIC in Quarter 3 based on the results from the Sepsis QII proposed in Quarter 2(December 2020) which was completed in March 2021. This recommendation was for a standalone sepsis training module/session. This was developed in conjunction with OOIH and the MRO Clinical Manager and is scheduled for 04 June 2021. In addition, sepsis posters as educational handouts from the Sepsis Alliance and the CDC have been distributed and posted by OIH."

ATTACHMENT 25 (C1#33.20)

When there was implementation of QI initiatives, data was presented at the MRC meetings, providing evidence that data was tracked by the MRC and reflected in the minutes of the MRC at periodic intervals.

Information shared included the following documents: MRC Data Report Q4.2020, MRC Data Report Q1 2021. MRC Data Report Q2 2021, and MRC Data Report Q3 2021, as well as the 202 MRC Annual Report.

The MRC meeting minutes of 10/22/20 indicated a draft report of the 2020 MRC Annual Report was to be emailed to the committee members for review. This included QII initiatives at various stages of approval and implementation.

The MRC meeting minutes of 12/3/20 documented that the FY 2021 Q Quarterly Data Report was reviewed with the MRC (including robust discussion by MRC members).

The MRC meeting minutes of 2/25/21 included documentation of the Quarterly Data Review for Q2 FY2021 with discussion by committee members.

At the 3/11/21 MRC meeting, minutes indicated a review of previously approved and implemented QII in addition to two proposed QIIs to be presented to the QIC on 3/22/21.

The MRC meeting minutes of 5/13/21 included documentation of review of the quarterly data report for Q3 FY 2021 There was also review of two possible QIIs for presentation to the QIC (subject matter concerned COVID 19 focus, and separately SIS levels).

The MRC meeting minutes of 5/27/21 documented a discussion of potential QIIS concerning increasing vaccination rates, as well as knowledge deficits for COVID 19.

The MRC meeting minutes of 6/10/21 reviewed ensuring QII standards, measurement and two QII that were previously proposed, and timelines were to be added prior to presentation to the QIC.

The MRC meeting minutes of 7/22/21 reviewed a prior QII proposal concerning caregiver burnout.

ATTACHMENT 26 (C1#33.20)

The following documents tracked the results of the QIIs implemented and reviewed at intervals by the MRC: MRC Data Report Q4.2020, MRC Data Report Q1 2021. MRC Data Report Q2 2021, and MRC Data Report Q3 2021.

As an example: From the MRC Data Report Q1 2021, a status of a QIC approved QII was updated for Goal: increase the number of I/DD death certificates available for mortality review for >90%. "During Q1FY21, 99% (98/99) of deaths which were reviewed within 90-days of death also had a death certificate which was received within 90-days. A second goal had been to increase the number of mortality review cases in which 911 protocol was followed with a target of >60%. The data indicated that during Q1FY21, 62% of deaths in which 911 protocol was a factor also had 911 protocols followed appropriately. As follow up to monitoring of recommendation implementation, the 'MRC Data Report Q2 2021' documented that during Q2 2021, 64% of deaths in which 911 protocol was a factor, also had

911 protocols followed appropriately, and that 96% of deaths reviewed within 90 days of death also had a death certificate which was received within 90 days. (71/74). The MRC Data Report Q3 FY2021' recorded 50% of deaths in which 911 protocol was a factor also had 911 protocols followed appropriately. For Q3 FY21 103% of deaths reviewed within 90 days had a death certificate

(The denominator was not inclusive of all deaths).

ATTACHMENT 27 (C1# 33.21)

Under the Risk Management section of this report, the following was noted: "The MRC (in collaboration with the RMRC [Risk Management Review Committee]) recommended that direct support professional training be reviewed to determine if it addressed provider policy requirements of staff initiation of CPR and calling 911 (prior to calling a director or another staff member)." Steps were taken to provide training by DBHDS OIH through provider round tables. The Office of Provider Development further updated the competencies to specifically indicate that 911 should be called before notifying anyone else of an emergency.

DBHDS OIH also reviewed, revised, developed and or provided alerts for home blood pressure monitoring (Jan 2020, Care Considerations and Epilepsy/seizure disorders (Mar 2020), constipation: care management, medication and recognizing bowel obstruction (Apr 2020), and stroke Awareness (May 2020). Also listed were 4 QII proposed by the MRC during SFY 2020: "propose legislation allowing MRC to obtain documents from agencies and facilities related to case review when/ as needed, Reduce the number of Potentially Preventable deaths to less than 15% of total DD deaths reviewed. Decrease the number of "Unknown as cause of death. Reduce the number of Potentially Preventable deaths where the factor in the death was failure to execute established protocol but increasing execution to the specific response protocol." This report also documented the responsibility of the MRC in monitoring the performance measurement indicator (PMI) related to unexpected deaths. The MRC made recommendations for all unexpected Potentially Preventable deaths in order to reduce mortality rates to the fullest extent practicable (remediation/corrective measures). "Most of the provider level recommendations were related to the corrective action plans issued by the OL, in addition to safety alerts created and distributed (via newsletter, emails, posting to website) by the OIH. "Included in this document was a copy of the 'Annual Mortality Report SFY 2020.

APPENDIX G

Provider Training

By

Chris Adams MS

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

Provider Training

Respectfully submitted by:

Chris Adams MS

November 13, 2021

Provider Training 19th Review Period Study

The Settlement Agreement in U.S. v. Commonwealth of Virginia requires the Commonwealth to ensure that all services for individuals receiving services under this Agreement are of good quality, meet individual's 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 have a statewide core competency-based training curriculum for all staff who provide services under this Agreement. For this 19th Period review, the related provisions are as follows:

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

The Parties (i.e., the Commonwealth of Virginia and the U.S. represented by DOJ) jointly submitted to the Federal Court a complete set of compliance indicators for all provisions with which Virginia had not yet been found in sustained compliance. The agreed upon compliance indicators were formally submitted on Tuesday, January 14, 2020. The Independent Reviewer's previous report with regard to these provisions, (i.e., his 17th Report to the Court, dated December 15, 2020), found the Commonwealth had met the requirements for compliance for one of the 2 provisions (V.H.2.) overall, and had met requirements for some of the associated Compliance Indicators (CIs) for the other (V.H.1).

For this 19th Period review, the Independent Reviewer again prioritized the study of the provisions set out above. As part of the study, he commissioned a focused qualitative review for Sections V.H.1 and V.H.2 (i.e., Provider Training Study) that included sampling compliance with provider training requirements. For clarity, the following introductory narrative is separated into two parts. Part I summarizes the study activities and findings for all Sections except for Sections V.H.1 and V.H.2, which are summarized in Part II.

Study Purpose and Methodology:
The Settlement Agreement in U.S. v. Commonwealth of Virginia requires in Section V.H that the Commonwealth have a statewide core competency-based training curriculum for all staff who provide services under this Agreement. The relevant provisions are Section V.H.1 and V.H.2, as described above.

Compliance with these provisions has been reviewed in the 5th, 7th, 10th/11th, 15th, and 17th reports of the Independent Reviewer. The Department of Behavioral Health and Developmental Services (DBHDS) began implementing its Provider Training Plan in 12/2015. The DBHDS Office of Provider Development (OPD) has taken the lead in this implementation effort. The Department of Medical Assistance Services (DMAS) is responsible for the primary regulatory oversight of provider implementation of core competency-based training and accomplishes this through their Quality Monitoring Review (QMR) process. Some requirements are regulated by the DBHDS Office of Licensing (OL).

In 2016, the Commonwealth made emergency modifications to regulatory requirements to establish an initial mechanism for review and enforcement, if necessary, of providers' adherence to the training requirements. These emergency regulations (12VAC30-120-515) related to the Waiver implementation,

were in effect from 09/01/2016 through 08/30/2018. When the emergency regulations expired on 08/30/2018, the Commonwealth began utilizing its waiver authority as outlined in the waiver applications (Community Living, Building Independence, and Family and Individual Support waivers) approved by the Centers for Medicare and Medicaid Services (CMS) as the basis for regulatory oversight. This continued until new regulations were approved and became effective on 03/31/2021.

On 01/14/2020, the Parties (i.e., the Commonwealth of Virginia and the U.S. represented by DOJ) jointly submitted to the Federal Court a complete set of compliance indicators for all provisions with which Virginia had not yet been found in sustained compliance. For this report, due in December 2021, the Independent Reviewer's monitoring priorities again include studying compliance with these agreed-upon compliance indicators.

The details included in the sixteen Compliance Indicators for V.H.1 and V.H.2 emphasize the importance of specific core competencies across the system as a whole. For example, those delineated for direct support staff and their supervisors require knowledge and performance skills related to the characteristics of developmental disabilities, positive behavior supports, effective communication, the identification of potential health risks, and aspects of community integration and social inclusion. Further, before a finding of Compliance can be achieved, DSPs and supervisory staff system-wide must meet measurable goals for the achievement of these core competencies.

The Independent Reviewer's 17th Report to the Court, dated December 15, 2020, noted evidence of considerable effort to meet the requirements of the Compliance Indicators related to Provider Training and that the Commonwealth is working diligently to ensure that provider staff are trained in the knowledge and performance competencies required for exercise of their job responsibilities, including protecting the health, safety, and well-being of the individuals with developmental disabilities (DD) who are reliant on their support.

The evaluation of compliance for Provision V.H.1 identified evidence sufficient to determine the Commonwealth had met Indicators 49.01, 49.05, 49.06, 49.07, 49.08, 49.09, and 49.13. However, there was not sufficient evidence presented to reliably confirm that the metrics for Indicators 49.02, 49.03, 49.04, 49.10, 49.11, and 49.12 were met. Commendably, the Commonwealth had met each of the three Indicators for developing and making available supervisory training and support and coaching resources, and therefore had achieved Compliance with Provision V.H.2.

The Independent Reviewer noted that the adequacy of the DMAS QMR and DBHDS OL DD Provider Inspections Checklist (now titled "OL Annual Checklist Compliance Determination Chart-FY2021") processes will be determined in subsequent reviews under Provision V.H.1-Compliance Indicator 49.02 and V.B-Compliance Indicator 29.02.

The purpose of this study was to gather and investigate facts and to verify data and documentation necessary to determine whether the Commonwealth has met the Compliance Indicators associated with Provisions V.H.1 and V.H.2. This study of the provider training requirements focused on determination of the Commonwealth's status regarding whether it has continued to meet the requirements for Provision V.H.1 associated Compliance Indicators 49.01, 49.05, 49.06, 49.07. 49.08, 49.09 and 49.13 and maintained Compliance for Provision V.H.2 and its associated Compliance Indicators 50.01, 50.02 and 50.03.

The study also focused on determining the Commonwealth's status requiring the Licensing Regulations detailed in Indicators 49.08, 49.09, 49.10, 49.11, and 49.12, and the extent to which Virginia has monitored the effectiveness of the providers' implementation of these regulatory requirements. In future review period

the Independent Reviewer will monitor the Commonwealth's performance related to these Indicators at 29.02.

The study activities included review of documents provided by DMAS and DBHDS, 10 interviews with 18 DBHDS and DMAS staff, a review of reports from 11 DMAS Quality Management Reviews conducted between 10/01/2020 and 06/30/2021, a review of 19 reports from annual Licensing inspections for eight licensed providers (the same providers identified in the DMAS QMR sample described above) conducted between 03/01/2021 and 06/30/2021, review of training policies for the 11 sample providers, and 11 interviews conducted with 28 staff members from the 11 sample providers across the Commonwealth – 10 provider interviews were conducted onsite and one was conducted virtually. A complete list of documents and data reviewed is included in Attachment A to this report. A complete list of individuals interviewed for the study may be found in Attachment B.

For the study, DMAS was requested to provide a list of all provider agencies for which a QMR review had been conducted and completed during the period 10/01/2020-06/30/2021. The list contained the names of 29 provider agencies. From that list of 29, a sample of agencies was selected based on several criteria. Selection focused on geographic/regional representation across the Commonwealth, the types of services the agency provides, whether or not the provider training requirements were relevant to the types of services the agency provides, and the size of the agency. Characteristics of the agencies selected:

- The sample included one agency in Region 1, two agencies in Region 2, two agencies in Region 3, two agencies in Region 4, and four agencies in Region 5.
- The sample included three Community Services Boards (CSBs) and eight private providers.
- The types of services provided and number providing that type of service included Group Day Support (5 providers), Group Home Residential (7 providers), Independent Living Supports (2 providers), Individual Supported Employment (1 provider), In-Home Support Services (1 provider), Sponsored Residential Services (2 providers), Companion Care (1 provider), Personal Assistance (2 providers), Respite Care (2 providers), and Supported Living Residential (1 provider).
- The numbers of persons served by each agency ranged from 4-98. 5 agencies served 1-10 individuals, 2 served 11-20 individuals, 1 served 21-50 individuals, and 3 served 51+ individuals.

DMAS provided copies of the QMR reports and corrective action plans for cited violations for each of the agencies. Nine of the agencies in the sample provide services that require a license. DBHDS OL provided copies of the Annual Licensing Inspection reports and related corrective action plans for the eight agencies whose services require a license (19 separate licensing inspections); the licensing inspections for one of the sample providers had not yet been completed in SFY 2021. Two of the agencies in the sample provide services that do not require a license. Each of the providers in the sample also sent a copy of their training policy(ies) for review prior to the onsite interview. Ten onsite interviews were conducted from Monday 09/27/2021-Friday 10/01/27. One agency interview was conducted via Zoom due to scheduling challenges with the staff most familiar with their training program.

The purpose and the related components of the study, including the plan to conduct onsite interviews with a sample of providers, were reviewed with DBHDS and DMAS staff prior to beginning the study. Following a kick-off meeting, DBHDS and DMAS were asked to provide documentary evidence to demonstrate their compliance efforts for each of the 16 compliance indicators and to suggest interviews that would provide information that demonstrates proper implementation of the Provisions and associated Compliance Indicators.

Summary of Findings:

The Commonwealth has continued to make significant progress in their efforts to develop and implement a statewide core competency-based training curriculum and to structure and conduct thorough and reliable regulatory oversight of provider implementation of this training curriculum. The efforts to develop, refine, and deliver useful and effective training curricula has remained focused to ensure that provider staff are trained in the knowledge and performance competencies required for exercise of their job responsibilities, including protecting the health, safety, and well-being of the individuals with developmental disabilities (DD) who are reliant on their support. Despite the significant restrictions that the COVID-19 pandemic imposed on providers, the Licensing Inspection Process, and the QMR process, work has continued to expand efforts to ensure that providers are fully implementing the core competency-based training requirements for DSPs and DSP Supervisors. DMAS discontinued onsite QMRs in mid-March 2020 moving exclusively to remote reviews and, to date, has not yet resumed onsite inspections. OL discontinued onsite licensing inspections in mid-March 2020 also using remote reviews exclusively until 04/01/2021. Since that time, onsite inspections have occurred unless the provider has had an issue with COVID exposure. The remote inspection processes significantly limited the thoroughness of licensing inspections as it precluded onsite interviews and the direct observations that result from this to verify staff competencies. The DMAS QMR record review process does not include these activities to verify that staff can demonstrate staff competencies.

During the 19th review period, new DMAS provider training regulations (12VAC30-122-180) were finalized and became effective 03/31/2021. Licensing regulations that are pertinent to the provision of competency-based training for all DSPs and DSP Supervisors (12VAC35-105-440, 450, 665d, 770 and 790) have been in place for a number of years but the DBHDS OL has continued to refine its inspection procedures related to these requirements and has continued to provide extensive training to providers on their content and implementation. A review of provider policies and interviews with provider staff reflected a consistent level of knowledge and familiarity with the relevant licensing requirements.

The DBHDS OPD has developed and implemented use of standardized training for DSPs and DSP Supervisors outlined in the DD Waiver Orientation and Competencies Protocol (Document #2), requirements for competency and proficiency assessment for DSPs and DSP Supervisors documented on the Developmental Disabilities and Supervisor Competencies Checklist (Document #3), and a standardized DSP Orientation Test (Document #15) that must be passed at 80% or higher prior to a DSP/Supervisor working independently with individuals. The use of these tools had begun prior to the 17th review period, but they have continued to be refined and improved since that time including the development and planned implementation of two expanded competencies addressing Choking (Document #16) and Change of Mental Status (Document #17) that will become a requirement on 11/15/2021. Advanced competencies addressing Health (Document #4), Autism (Document #5), and Behavioral Supports (Document #6) are required for DSPs/Supervisors working with individuals at Tier IV Levels 5, 6 & 7 related to any of these three areas.

DMAS regulations relating to core competency-based training requirements (12VAC30-122-180) were approved and became effective on 03/31/2021 with enforcement beginning 05/01/2021. DMAS assesses provider compliance with core competency-based training requirements within its Quality Monitoring Review (QMR) process. DMAS reports that it has decided to make changes to their QMR process to incorporate the requirements of these new regulations in reviews that begin on or after 10/01/2021. These reviews will include review of provider compliance on or after the 05/01/2021 enforcement date. The DMAS QMR process did not use the new regulations as its basis for determination of regulatory compliance during the six months of the 19th Review Period. DMAS also reported that of the hundreds of agencies in Virginia with thousands of DSPs and DSP supervisors providing waiver-funded services, that it conducted and completed QMR reviews of only 29 providers during all of the 18th and the first half of the 19th Review Periods (10/1/20-6/30/21.)

DMAS is currently in the process of developing a detailed set of instructions that correlate with the new regulations. DMAS reports that its Health Care Compliance Specialists will begin conducting the QMR reviews based on the new regulations during the first quarter of the 20th Review Period. However, during this review DMAS did not provide a date by which it will complete the new instructions, nor did it provide a draft of its instructions or indicate that the annual sample size for future QMR reviews will be sufficient to generalize the QMR findings to "all staff who provide services under this Agreement". This study, therefore, was not able to review the new DMAS instructions or to verify that they are sufficient to resolve the inadequacies in the current QMR process and the sampling methodology. DMAS has not established a specific date for completing and providing the new set of instructions that will guide future QMR reviews.

The current QMR review process was found to be insufficient to adequately evaluate, or generalize its findings, regarding whether all "DSPs/Supervisors, including contracted staff" meet the training and core-competency requirements specified in Compliance Indicator 49.02. The use of provider documentation as the sole basis to verify that the provider's services meet all waiver requirements is not a sufficient basis for determining whether the Commonwealth has achieved the requirements in Provision V.H.1. and its associated Compliance Indicators 49.02 and 49.03. The DMAS review process does not include a review of the provider's relevant policies that require its staff to complete competency-based training or the providers' procedures that detail how such training is delivered. The DMAS review also does not review any provider documentation related to the provider ensuring that staff who have not passed "a knowledge-based test … are accompanied and overseen by other qualified staff …". The DMAS QMR also does not include interviews with DSPs or DSP Supervisors to verify information documented on the provider's Competency Checklist.

With the use of the new provider training regulations (12VAC30-122-180) in the QMR process beginning 10/01/2021, using data from QMR reviews prior to 10/01/2021 to measure the 95% compliance percentage required for compliance with Compliance Indicator 49.04 is not a valid measurement of whether DSPs and their supervisors receive training and competency testing per regulation 12VAC30-122-180. Based on current timelines, the first available data that is relevant to the requirements at 12VAC30-122-180 will not be available until the 01/01/2022 or after.

The current OL annual inspection protocol and practices were reviewed as they relate to provider training, specifically compliance with 12VAC35-105-440, 450, 665d, 770 and 790. OL has continued to refine the guidance document, the OL Annual Checklist Compliance Determination Chart-FY2021 (Document #166), used to train Licensing Specialists and as a reference tool for the Specialist while conducting annual inspections. The documents reviewed, the on-site interviews with provider staff and interviews with DBHDS licensing specialist confirmed that the licensing inspection procedures addressed in Compliance Indicators 49.08, 49.09, 49.10, 49.11, and 49.12 were found to be thorough, the licensing specialists interviewed demonstrated significant detailed knowledge of the regulations and the requirements for evaluating provider compliance with those regulations.

Compliance Indicator 49.13 requires that DBHDS, in conjunction with DMAS QMR staff, review citations and make results available to provide through quarterly provider roundtable meetings. The results from DMAS QMRs, including identified trends and patterns, are consistently being presented in the Quarterly Provider Roundtable meetings. This presentation does not currently include findings from OL annual inspections. It is this reviewer's considered opinion that inclusion of additional information from the OL annual inspections would be helpful to providers.

The DBHDS OPD and Office of Integrated Health (OIH) have continued to develop and expand training, online resources, consultation, and technical assistance for nurses, behaviorists, DSP Supervisors, and other provider staff consistent with the requirements at Compliance Indicators 49.05, 49.07, 50.01, 50.02, and

50.03. Providers interviewed stated awareness of these resources and noted their specific appreciation for the Quarterly Provider Roundtable meetings which each stated they tried very hard to attend regularly, expressing a desire to increase the frequency of these information sharing meetings to every two months given the significant amount of useful information shared there.

Conclusion:

The table on the following pages illustrate the current compliance status for each Compliance Indicator in this section:

V.H.1 Indicators	Status
49.01: DBHDS makes available an Orientation Training and Competencies Protocol that communicates DD Waiver requirements for competency training, testing, and observation of Direct Support Professionals (DSPs) and DSP supervisors.	Met
49.02: The Commonwealth requires DSPs and DSP Supervisors, including contracted staff, providing direct services to meet the training and core competency requirements contained in DMAS regulation 12VAC30-122-180, including demonstration of competencies specific to health and safety within 180 days of hire. The core competencies include: a. the characteristics of developmental disabilities and Virginia's DD Waivers; b. person-centeredness (and related practices such as dignity of risk and self-determination in alignment with CMS definitions); c. positive behavioral supports; d. effective communication; e. at a minimum, the following identified potential health risks of individuals with developmental disabilities and appropriate interventions: choking, skin care (pressure sores, skin breakdown), aspiration pneumonia, falls, urinary tract infections, dehydration, constipation and bowel obstruction, change of mental status, sepsis, seizures, and early warning signs of such risks, and how to avoid such risks; f. community integration and social inclusion (e.g., community integration, building and maintaining positive relationships, being active and productive in society, empowerment, advocacy, rights and choice, safety in the home and community); and g. DSP Supervisor-specific competencies that relate to the supervisor's role in modeling and coaching DSPs in providing person-centered supports, ensuring health and wellness, accurate documentation, respectful communication, and identifying and responding to changes in an individual's status.	Not Met
49.03: DSPs and DSP Supervisors who have not yet completed training and competency requirements per DMAS regulation 12VAC30-122-180, including passing a knowledge-based test with at least 80% success, are accompanied and overseen by other qualified staff who have passed the core competency requirements for the provision of any direct services. Any health-and-safety-related direct support skills will only be performed under direct supervision, including observation and guidance, of qualified staff until competence is observed and documented.	Not Met
49.04: At least 95% of DSPs and their supervisors receive training and competency testing per DMAS regulation 12VAC30-122-180.	Not Met

V.H.1 Indicators	Status
49.05: DBHDS makes available for nurses and behavioral interventionists training, online resources, educational newsletters, electronic updates, regional meetings, and technical support that increases their understanding of best practices for people with developmental disabilities, common DD-specific health and behavioral issues and methods to adapt support to address those issues, and the requirements of developmental disability services in Virginia, including development and implementation of individualized service plans.	Met
49.06: Employers and contractors responsible for providing transportation will meet the training requirements established in the DMAS transportation fee for service and managed care contracts. Failure to provide transportation in accordance with the contracts may result in liquidated damages, corrective action plans, or termination of the vendor contracts.	Met
49.07: The DBHDS Office of Integrated Health provides consultation and education specific to serving the DD population to community nurses, including resources for ongoing learning and development opportunities.	Met
49.08: Per DBHDS Licensing Regulations, DBHDS licensed providers, their new employees, contractors, volunteers, and students shall be oriented commensurate with their function or job-specific responsibilities within 15 business days. The provider shall document that the orientation covers each of the following policies, procedures, and practices: a) Objectives and philosophy of the provider; b) Practices of confidentiality including access, duplication, and dissemination of any portion of an individual's record; c) Practices that assure an individual's rights including orientation to human rights regulations; d) Applicable personnel policies; e) Emergency preparedness procedures; f) Person-centeredness; g) Infection control practices and measures; h) Other policies and procedures that apply to specific positions and specific duties and responsibilities; and **i)** Serious incident reporting, including when, how, and under what circumstances a serious incident report must be submitted and the consequences of failing to report a serious incident to the department in accordance with the Licensing Regulations.	Met
49.09: The Commonwealth requires through the DBHDS Licensing Regulations specific to DBHDS-licensed providers that all employees or contractors who are responsible for implementing an individual's ISP demonstrate a working knowledge of the objectives and strategies contained in each individual's current ISP, including an individual's detailed health and safety protocols.	Met
49.10: The Commonwealth requires all employees or contractors without clinical licenses who will be responsible for medication administration to demonstrate competency of this set of skills under direct observation prior to performing this task without direct supervision.	Met
49.11: The Commonwealth requires all employees or contractors of DBHDS-licensed providers who will be responsible for performing de-escalation and/or behavioral interventions to demonstrate competency of this set of skills under direct observation prior to performing these tasks with any individual service recipient.	Met

V.H.1 Indicators	Status
49.12: At least 86% of DBHDS licensed providers receiving an annual inspection have a training policy meeting established DBHDS requirements for staff training, including development opportunities for employees to enable them to support the individuals receiving services and to carry out their job responsibilities. These required training policies will address the frequency of retraining on serious incident reporting, medication administration, behavior intervention, emergency preparedness, and infection control, to include flu epidemics. Employee participation in training and development opportunities shall be documented and accessible to the department. DBHDS will take appropriate in action in accordance with Licensing Regulations if providers fail to comply with training requirements required by regulation.	Not Met
49.13: Consistent with CMS assurances, DBHDS, in conjunction with DMAS QMR staff, reviews citations (including those related to staff qualifications and competencies) and makes results available to providers through quarterly provider roundtables.	Met

V.H.2 Indicators	Status
50.01: DSP Supervisors are responsible for adequate coaching and supervision of their staff trainees. As part of its training program, DBHDS will develop and make available a supervisory training for all DSP supervisors who are required to complete DSP training and testing per DMAS Waiver Regulations in DBHDS-licensed and non-DBHDS-licensed agencies as described in DMAS Waiver Regulations.	Met
50.02: DBHDS will develop and make available a supervisory training for all DSP supervisors who are required to complete DSP training and testing per DMAS Waiver Regulations in DBHDS-licensed and non-DBHDS-licensed agencies as described in DMAS Waiver Regulations. At a minimum, this training shall include the following topics: a) skills needed to be a successful supervisor; b) organizing work activities; c) the supervisor's role in delegation; d) common motivators and preventive management; e) qualities of effective coaches; f) employee management and engagement; g) stress management; h) conflict management; i) the supervisor's role in minimizing risk (e.g., health-related, interpersonal, and environmental); j) mandated reporting; and k) CMS-defined requirements for the planning process and the resulting plan.	Met
50.03: In addition to training and education, support and coaching is made available to DBHDS-licensed providers through the DBHDS Offices of Integrated Health and Provider Development upon request and through community nursing meetings, provider roundtables, and quarterly support coordinator meetings to increase the knowledge and skills of staff and supervisors providing waiver services. DBHDS will compile available support and coaching resources that have been reviewed and approved for placement online and ensure that DBHDS-licensed providers are aware of these resources and how to access them.	Met

V.H.1-V.H.2 Analysis of 19h Review Period Findings

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

V.H.2: The 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.

Compliance Indicator	Facts	Analysis	Conclusion
49.01: DBHDS makes available an Orientation Training and Competencies Protocol that communicates DD Waiver requirements for competency training, testing, and observation of Direct Support Professionals (DSPs) and DSP supervisors.	DBHDS issued the most current iteration of the "Direct Support Professional (DSP) and DSP Supervisor DD Waiver Orientation and Competencies Protocol" on 03/06/2020. This protocol contains requirements for staff orientation training and core competency identification, testing, and initial/ongoing proficiency confirmation. (Documents 2 & 18) The Direct Support Professional Orientation training is housed on the	DBHDS through the Office of Provider Development (OPD) continues to refine and improve training and core competency measurement processes required for all DSPs and DSP Supervisors who provide direct services under the DD waivers. OPD published the most current iteration of the "Direct Support Professional (DSP) and DSP Supervisor DD Waiver Orientation and Competencies Protocol" on 03/06/2020. The Protocol is a comprehensive and detailed description of the training requirements and the provider's responsibilities to assure that all DSPs and DSP Supervisors receive the required core competency training and testing that must be completed prior to providing direct services. The Protocol details requirements for DSP and DSP Supervisor proficiency certification that must be successfully completed within 180 days from date of hire and updated annually thereafter. DBHDS published a notice to providers regarding the newly revised DD Waiver Orientation and Competencies Protocol on 03/27/2020. The DSP Orientation Training is an online curriculum required for all DSPs and DSP Supervisors and it is accessed through the Virginia Commonwealth University Partnership for People with Disabilities website. The website contains the Competencies Protocol, The DSP Assurance and Supervisor Assurance documents, the Basic Competencies Checklist, the Advanced	17th Period-Met 19th Period-Met

Compliance Indicator	Facts	Analysis	Conclusion
	Virginia Commonwealth University Partnership for People with Disabilities website. This training includes a 6-module training course, the Basic Competencies Checklist, the DSP Orientation Test, and information relating to each of the advanced competencies. (Documents 3, 14, 5, 6, & 15) DBHDS has recently revised the training curriculum to expand the basic competencies training content to address more fully "change in mental status" and "choking". These new modules will become a requirement for all DSPs and DSP Supervisors on 11/15/2021. (Documents 14, 16, 17, and interviews with DBHDS OPD director)	Competencies Checklists addressing health, behavioral, and autism competencies, and the DSP Orientation Test. DSP supervisors must complete online training and testing through the Commonwealth of Virginia Learning Center. This is a web-based application that delivers three self-study training modules for DSP supervisors. The three modules are entitled Enhancing Supervisory Skills, Enhancing Employee Performance, and Leadership Excellence Among Developmental Disabilities Supervisors. The site also includes the required supervisor competency test. Once the test is successfully completed, the supervisor is provided a certificate of completion through the site. While the impact of COVID-19 increased staffing challenges for providers significantly, DMAS/DBHDS did not relax any of the core competency training and testing requirements. DMAS considered some time extension on the 180-day proficiency measurement if documentation was on file that circumstances prevented the confirmation of proficiency during the state of emergency related to COVID-19. OPD conducted five regionally based DSP Orientation and Competencies Overview Webinars on 11/04, 11/05, and 11/06/2020 to review the purpose and benefits of having competent staff and the requirements for DSPs and DSP Supervisors to be trained and deemed proficient in both basic, and, if needed, advanced competencies. Attendance records for these webinars documented 581 participants. OPD developed the "DSP Training and Competencies Webinar-FY21" that provides a comprehensive overview of the purpose and requirements for competency training, testing, and proficiency measurement. The webinar also covers how the provider's compliance with these requirements is measured and the possible actions to be taken if the provider is found not to be in compliance. The recording of the "DSP Training and Competencies Webinar-FY21", the accompanying PowerPoint presentation, and a DSP Orientation and	

Compliance Indicator	Facts	Analysis	Conclusion
	DBHDS requires all DSP Supervisors to complete the 3-module supervisory training self-study course that is accessed through the Commonwealth of Virginia Learning Center. DBHDS maintains significant reference materials on its Centralized Training for Providers Website that relate to the DD Waiver Orientation and Competencies Protocol. They have conducted regional trainings, developed and published a training webinar and developed an FAQ document as resources for providers regarding their responsibilities for DSP and DSP Supervisor training and competency verification. (Documents 7, 9, 10, 11, 12, 13, and interview with OPD director)	Competencies FAQ document can be accessed through the Provider Hub Website. DBHDS continues to review and revise DSP/Supervisor training curricula and on 09/17/2021, they posted a notice on the Listserv announcing revisions to the DSP Training Requirements. This includes a revised and expanded training curriculum on "Change in Mental Status" and "Choking" as well as related revisions to the DSP Orientation Test incorporating this new material. These new training modules and the new test are required for all DSPs and Supervisors beginning 11/15/2021. From interviews with 11 providers as a part of this study, 10 of 11 confirmed their knowledge and use of the DSP/Supervisor training curriculum, the competency test, and the competency checklist. One agency that provides only in-home agency-directed personal assistance services stated they were not aware of either the competencies test or the competencies checklist. Because this became a requirement for non-licensed agencies under the new DMAS regulations, this was not cited as a violation in the agency's most recent QMR review that occurred at the end of CY2020, which was prior to the approval of the DMAS regulations on 3/31/21, . Based on documentary evidence, interviews with DBHDS staff, and interviews with 11 providers, there is sufficient evidence that DBHDS has continued to improve and expand the Orientation Training and Competencies Protocol for competency training, testing, and observation of Direct Support Professionals (DSPs) and DSP supervisors, that this information is available to access through multiple electronic portals, and that providers are aware of and utilize these resources in their staff training programs.	

Compliance Indicator	Facts	Analysis	Conclusion
49.02: 2. The Commonwealth requires DSPs and DSP Supervisors, including contracted staff, providing direct services to meet the training and core competency requirements contained in DMAS regulation 12VAC30-122-180, including demonstration of competencies specific to health and safety within 180 days of hire. The core competencies include: a. the characteristics of developmental disabilities and Virginia's DD Waivers; b. person-centeredness (and related practices such as dignity of risk and self-determination in alignment with CMS definitions); c. positive behavioral supports; d. effective communication; e. at a minimum, the following identified potential health risks of individuals with developmental disabilities and appropriate interventions: choking, skin care (pressure sores, skin breakdown),	New regulations at 12VAC30-122-180 became effective 03/31/2021 and enforced as of 05/01/2021. While DMAS has notified providers of the effective date of the new regulations, they have not yet begun conducting assessments of compliance with these new regulations through the Quality Management Review (QMR) process and are not currently evaluating provider compliance with each of the requirements contained in 12VAC30-1212-180. DMAS stated they will begin review and determination of compliance with the new regulations in Quality Management Reviews (QMRs) on 10/01/2021. (Documents 19, 20, Interviews with DMAS staff)	The final version of the revised DMAS regulations for the DD Waivers became effective on 03/31/2021 and enforced as of 05/01/2021. The approved regulatory changes included new and more detailed regulations found at 12VAC30-122-180 that are pertinent to this Compliance Indicator. The regulation at 12VAC30-122-180 dated 03/31/2021 references each of the seven required core competencies contained in this Compliance Indicator and advanced competency requirements for DSPs and DSP Supervisors serving individuals with the most intensive needs who are assigned to Tier IV or at other support levels who are receiving a customized rate. The regulation also establishes requirements for training, competency testing, and initial and ongoing proficiency verification of DSPs and DSP Supervisors. DMAS sent an announcement to providers on 03/22/2021 notifying them that the new regulations would be implemented beginning 05/01/2021 allowing "a small period of transition" for providers and instructing them to "prepare accordingly for program changes, audits, and quality reviews." DMAS staff stated that they will begin review and determination of compliance with the new regulations in Quality Management Reviews (QMRs) beginning 10/01/2021. DMAS is developing a guidance document for its Health Care Compliance Specialists to use as a guide when conducting QMR reviews. A first draft of this guidance document has been drafted but a specific date for its completion has not yet been set. Because DMAS has not yet completed revised procedures and training for the Health Care Compliance Specialists who conduct the QMR reviews and because they stated they will begin review and determination of provider compliance with these new regulations on or after 10/01/2021, it is not possible at this time to assess how effective the QMR process is in measuring the requirements for DSPs and DSP Supervisors to meet the new and more detailed and specific training and core competency requirements contained in DMAS regulation 12VAC30-122-180 and referenced in this Compliance Indicator.	17th-Not Met 19th-Not Met

Compliance Indicator	Facts	Analysis	Conclusion
aspiration pneumonia, falls, urinary tract infections, dehydration, constipation and bowel obstruction, change of mental status, sepsis, seizures, and early warning signs of such risks, and how to avoid such risks; f. community integration and social inclusion (e.g., community integration, building and maintaining positive relationships, being active and productive in society, empowerment, advocacy, rights and choice, safety in the home and community); and g. DSP Supervisor-specific competencies that relate to the supervisor's role in modeling and coaching DSPs in providing person-centered supports, ensuring health and wellness, accurate documentation, respectful communication, and identifying and responding to changes in an individual's status.	12VAC30-122-180.B requires that "Waiver providers shall ensure that DSPs and DSP supervisors, including relief and contracted staff, complete competency observation and the competency checklist within 180 days from date of hire." (Document 19) 12VAC30-122-180A.1.a-e requires that each DSP and DSP Supervisor providing services to individuals with developmental disabilities must receive or have received training on the following knowledge, skills, and abilities: (a) The characteristics of developmental disabilities and Virginia's Waivers; (b) Person-centeredness, positive behavior supports, and effective communication; (c) Identified potential health risks of	Through interviews with the 11 providers in the sample, the methods, intensity, and duration of the initial competency-based training provided to DSPs and DSP Supervisors was found to vary widely. Two of the providers, in describing their initial training and testing of DPSs, stated that it took less than six hours to complete. Others described the process as taking a minimum of one week and more frequently two plus weeks including the successful passing of the Competency Test. DMAS Health Care Compliance Specialists stated that they do not conduct interviews with provider staff as a required element of the QMR process. Without interviews with relevant staff at these agencies, the QMR process is not sufficient. With the current process it is highly unlikely that DMAS's Health Care Compliance Specialist would identify any concerns about the use of highly abbreviated training and competency verification procedures described by those providers in the sample who indicated their training/testing could be successfully completed in six hours or less. In fact, the most recent QMR report for these agencies, which utilized the current DMAS process did not identify any of these concerns through its review of training documentation. Based on analysis of documentary evidence, interviews with DMAS staff, and interviews with eleven providers, there was insufficient evidence identified to demonstrate that the current DMAS QMR process is structured to evaluate provider compliance with the training requirements outlined in DMAS regulation 12VAC30-122-180 adequately or sufficiently. DMAS Health Care Compliance Specialists will not begin evaluation of compliance with the new and expanded requirements at 12VAC30-122-180 until 10/2021 at the earliest. Further, the current QMR process does not evaluate each of the new requirements contained in the regulation, does not require review of the provider's training policy/procedure, and does not contain a validation procedure that includes interviews or observation of DSPs/Supervisors to verify that DSPs/Supervisors can demonstrate required competencies.	

Compliance Indicator	Facts	Analysis	Conclusion
	individuals with developmental disabilities and the appropriate interventions; (d) Community integration and social inclusion; and (e) Best practices in the support of individuals with developmental disabilities. (Document 19) The DSP Competencies Checklist most recently revised in 07/2021 details specific supervisor competencies that must be achieved by each DSP Supervisor including serving as a model for DSPs by demonstrating respectful communication; Communicating the expectations and responsibilities to the DSPs they supervise; providing DSPs with guidance or taking remedial action to the extent necessary to ensure the provision of services and necessary documentation; and		

Compliance Indicator	Facts	Analysis	Conclusion
	providing guidance to DSPs on identifying individual-specific changes that may indicate the need for an emergency response or team meeting. (Document 72) 12VAC30-122-180.A.2 requires that DSPs and DSP Supervisors pass, with a minimum score of 80%, a DMAS-approved objective, standardized test of knowledge, skills, and abilities. That standardized test includes questions that relate to each of the seven core competencies listed in this Compliance Indicator. (Document 19) 12VAC30-122-180.B requires documentation of competency training, successful completion of the DSP Orientation Test, and proficiency confirmation within 180		

Compliance Indicator	Facts	Analysis	Conclusion
	days of employment documented on the Developmental Disabilities DSP and Supervisor Competencies Checklist and attested on the Direct Support Professional Assurance and Supervisor Assurance forms. (Document 19) DMAS assesses provider compliance with core competency-based training requirements within the DMAS Quality Monitoring Review (QMR). For reviews to be conducted each quarter, they identify specific provider organizations to be reviewed and use a statistically valid sampling of individuals served by the provider that is based on total waiver enrollment. New waiver service providers must be reviewed within the first 12 months of their operation.		

Compliance Indicator	Facts	Analysis	Conclusion
	Community Services Boards (CSBs) must be reviewed every three years. Existing waiver providers are selected for review based on a number of variables but there is no specific interval for an existing provider to be reviewed. (Document #26)		
49.03: DSPs and DSP Supervisors who have not yet completed training and competency requirements per DMAS regulation 12VAC30-122-180, including passing a knowledge-based test with at least 80% success, are accompanied and overseen by other qualified staff who have passed the core competency requirements for the provision of any direct services. Any health-and-safety-related direct support skills will only be performed under direct supervision, including observation and guidance, of qualified staff until competence is observed and documented.	12VAC30-122-180.A.2 requires that "other qualified staff who have passed the knowledge-based test shall work alongside any DSP or supervisor who has not yet passed the [DMAS-approved objective, standardized] test." (Document 73) 12VAC30-122-180.B.4 requires that the health and safety related direct support skills contained in the competencies checklist under Competency 3 will only be performed under direct supervision, including observations	The final version of the revised DMAS regulations for the DD Waivers became effective on 03/31/2021 and enforced as of 05/01/2021. The regulation at 12VAC30-122-180.A.2 contains language pertinent to this Compliance Indicator. The regulation requires that providers ensure that DSPs and DSP supervisors pass a DMAS-approved objective, standardized test of knowledge, skills, and abilities with a minimum score of 80% prior to providing direct services; that qualified staff who have passed the knowledge-based test must work alongside any DSP or supervisor who has not yet passed the test; and that health and safety related direct support skills contained in the competencies checklist will only be performed under direct supervision, including observations and guidance, of Qualified staff until competence is observed and documented. The DMAS-approved "DSP Orientation Test" includes 91 questions that address the following categories of information: values that support life in the community (19 questions), introduction to developmental disabilities (10 questions), waivers for people with developmental disabilities (12 questions), communication (14 questions), positive behavioral support (11 questions), and health and safety (25 questions). The health and safety section includes questions relating to change in appearance, behavior or manner; diet; skin breakdown; aspiration pneumonia; falls; urinary tract infections; dehydration; constipation; sepsis; and seizures. The test was revised on 07/01/2021 to include supplemental sections addressing choking (10 questions) and change in	17th-Not Met 19th-Not Met

Compliance Indicator	Facts	Analysis	Conclusion
	and guidance, of qualified staff until competence is observed and documented." (Document 73) The DSP Competencies Checklist contains 13 health and safety-related competencies, skills and abilities under the heading "Competency 3 - Demonstrates abilities that improve or maintain the health and wellness of those they support." Two confirmations are required for all skills listed under Competency 3. For the first confirmation, the DSP/Supervisor must be confirmed "competent" in all 13 health and safety-related competencies, including passing the DMAS-approved standardized test at 80% or higher, prior to working in the absence of staff who have been determined proficient in this area.	mental status (10 questions). These two sections address these topics in greater detail than they are addressed in the health and safety section referenced above. Providers must begin using the revised curriculum and test that includes these two expanded sections on 11/15/2021, during the 20th Review Period.. Based on information provided by DMAS Health Care Quality Specialists interviewed for this study, the current QMR process assesses whether each DSP/Supervisor had competency and proficiency verified within 180 days of employment, but the process does not currently require or include review evidence to determine if staff members who have not yet had competency verified are working with individuals without supervision of an individual who has achieved all of the competencies. From interviews with 11 providers, each stated they were aware of this requirement and that, through various internal operating procedures, were assuring that DSPs/Supervisors who had not yet demonstrated competence were not allowed to work independently with individuals. When asked how they documented this assurance, the only evidence identified was attendance rosters maintained in homes and day program sites. This evidence is not currently being reviewed in the QMR process and is not compared with dates on the Competency Checklist to verify compliance. Providers of personal assistance services that were interviewed had training procedures that assured each DSP was trained on the requirements of the individual support plan prior to initiating services unsupervised, but DMAS is also not currently verifying this requirement through the QMR process for those providers who do not require a license to deliver their services, e.g., personal assistance services. While each of the 11 providers in the sample described awareness of this requirement and described various methods to assure it is being carried out, information from interviews with DMAS staff and review of current instructions to the Health Care Compliance Specialists did not identify evidence to	

Compliance Indicator	Facts	Analysis	Conclusion
	The second confirmation is to determine "proficiency" and must be confirmed by the supervisor based on observation of the individual in the work setting within 180 days of hire. (Document 74)	demonstrate that the requirements of this compliance indicator are being specifically assessed during the QMR review. Without that specific assessment, it is not possible for the Commonwealth to determine the degree to which compliance with the requirements in this indicator are being met by providers.	
49.04: At least 95% of DSPs and their supervisors receive training and competency testing per DMAS regulation 12VAC30-122-180.	12VAC30-122-180, which became effective 03/31/2021 and enforced as of 05/01/2021, requires that DSPs and DSP Supervisors providing services to individuals with developmental disabilities receive or have received training on specified knowledge, skills and abilities; that DSPs and DSP Supervisors pass or have passed, with a minimum score of 80%, a DMAS approved objective, standardized test of required knowledge, skills and abilities; and that DSPs and DSP Supervisors complete competency	DMAS regulations at 12VAC30-122-180 became effective on 03/31/2021 and enforced as of 05/01/2021. DMAS staff described the evolution of the regulation development noting that emergency regulations were put in place in 9/1/2016 and expired on 8/30/2018. After that time, regulatory compliance determinations were based on requirements language in the approved waiver applications. DMAS staff acknowledged that the waiver application language was less specific than the new requirements which, at times, prevented a provider being cited for the specific requirements that are articulated in the Settlement Agreement and/or the Compliance Indicators. DBHDS established two Key Performance Measures (KPMs) that comprise their measurement of achievement of the 95% threshold requirement in this Compliance Indicator. The source data that inform this percentage calculation come from the compliance determinations through the DMAS QMR process. As noted above, the regulatory basis for compliance determination based on language in the waiver assurances, being stated in somewhat general terms, did not always allow DMAS to cite a provider for non-compliance with the specific requirements of the Compliance Indicators.	17th-Not Met 19th-Not Met

Compliance Indicator	Facts	Analysis	Conclusion
	observations and verification and document this verification on the competency checklist within 180 days from date of hire. The DMAS Quality Management Review (QMR) process is the regulatory oversight process that the Commonwealth utilizes to measures provider compliance with relevant regulations including those related to provider training. (Document 78) DBHDS established two Key Performance Measures (KPMs) that measure achievement of the 95% threshold requirement in this compliance indicator. The source data that inform this percentage calculation come from the compliance determinations through the DMAS QMR	The "Provider Data Summary May 2021" includes the most currently available data for the two DBHDS Key Performance Measures (PMs) which correspond to this Compliance Indicator: (1) PM C8 requires that 95% of provider agency staff meet provider orientation training requirements. Following is quarterly percentage compliance for this measure across all waivers for the most recent three quarters for which data is available: Q4-20–93.2%; Q1-21–70.0%; Q2-21–87.1%. The 95% required compliance threshold was not met in any of these three quarters. (2) PM C9 requires that 95% of provider agency DSPs meet competency training requirements. Following is quarterly percentage compliance for this measure across all waivers for the most recent three quarters for which data is available: Q4-20–95.0%; Q1-21–37.5%; Q2-21–53.3%. The 95% required compliance threshold was met in Q4-20 but has been significantly lower in each of the two succeeding quarters. These substantial variations of Provider adherence to the 95% requirement raise significant questions regarding the reliability and validity of the data reported. To address the fact that compliance with these two performance measures has consistently been below the 95% compliance level, DBHDS conducted five regional webinars in 11/2020 to review the updated training and competency requirements in the DSP and DSP Supervisor DD Waiver Orientation and Competencies Protocol, dated 03/06/2020. A sixth invitational webinar was held in 01/2021 for providers who had received a provider training-related citation in SFY-19. Training records provided documented participation of 595 people in these webinars. Region 3 developed and implemented a Quality Improvement Initiative (QII) in 08/2020 to increase the percentage of DSPs who are trained and competent. The target for the QII was to improve DSP competency completion to 86% from a baseline of 56% in 2019. The Q4-2021 Report to the QIC includes data for "Orientation Training" and "Observed Competencies" that showed significant decline from Q4-2020 to Q1-2021. The 4th Quarter report indicates the status of this project as "completed" but only one of the five listed activities	

Compliance Indicator	Facts	Analysis	Conclusion
	process; however, these determinations are not based on the current requirements at 12VAC30-122-180 which became effective 03/31/2021. The new regulations that became effective 03/31/2021 include the specific provider training requirements in the Settlement Agreement and the relevant Compliance Indicators. (Documents 79, 80, 81, 82, and interviews with DMAS staff) Evidence of data collected relevant to these compliance indicators to date (Key Performance Measures C8 and C9) has shown that provider compliance with the regulatory requirements that were previously in place (those prior to the implementation of the current requirements at 12VAC30-122-180) had not achieved the 95%	(the five regional webinars held in 11/2020) includes evidence of completion. Others are noted as "beginning process", "discussions underway", "ongoing", and "continuing". Based on information provided, the QII has not yet demonstrated success in achieving the targeted level of improvement. Another improvement initiative that has been implemented includes updated and expanded DSP Supervisory Training made available to DSP Supervisors through the Commonwealth of Virginia Learning Center. This training is mandatory for new DSP Supervisors and optional for DSP Supervisors who have already received a certificate of completion of the previous version of the training. 293 supervisors completed the training from 05/2020-10/2020 and 295 supervisors completed the training from 11/2020-04/2021. DBHDS was not able to provide an estimated number of DSP Supervisors that they believe require this training. Without that estimation of the universe or supervisors, it is not possible to determine the percentage of supervisors that have received the training to date. In future reporting, the estimated universe of supervisors must be reported so that the denominator of the required 95% quotient can be more accurately determined. The current QMR process does not include sample selection and evidence review that addresses each of the required elements contained in 12VAC30-122-180. The personnel sampling procedures do not assure review of evidence to verify that a staff member does not work independently prior to completing all of the required training modules and passing the competency test at 80% or higher. Additionally, the personnel sample, if the provider serves an individual assigned to Tier IV, does not require inclusion of that individual in the sample and therefore does not assure review of relevant training records to assess compliance with the specific requirements set out in 12VAC30-122-180.C that address required advanced core competencies. While the regulations at 12VAC30-122-180 became effective on 03/31/2021 and DMAS began measurement of provider compliance with the new regulations on 10/01/2021, the beginning of the 20th Review Period, giving	

Compliance Indicator	Facts	Analysis	Conclusion
	threshold. (Documents 79, 80, 81 & 82) DMAS began measurement of provider compliance with the provider training regulations at 12VAC30-122-180 on 10/01/2021. For this reason, data specific to compliance with these new regulations, the specific requirement of this Compliance Indicator, will not be available until, at the earliest, the end of the second quarter of SFY 2022, 12/31/2021. (Interviews with DMAS staff) The current QMR process does not include sample selection and evidence review that addresses each of the required elements contained in 12VAC30-122-180. (Document 92, interviews with DMAS staff)	providers time to adapt their policies, procedures, and practices to describe how they will comply. With measurement of compliance with the new regulations through the QMR process beginning 10/01/2021 at the earliest, source data reflective of compliance with the new regulations will not be available to measure compliance with these KPMs prior to the end of the second quarter of state fiscal year 2022 (12/31/2021), the second half of the 21st Review Period. DMAS was asked on 08/25/2021 to provide a list of all QMRs that were completed during the period 10/01/2020-06/30/2021. They provided a list of 29 completed reviews which included 9 CSBs and 20 private providers. DMAS acknowledged that the number of agencies identified for QMR each quarter varies based on the size of each organization (larger organizations take more time and resources to complete). Currently, DMAS completes a QMR on each CSB at least once every three years but does not require a specific time interval for completion of QMRs on non-CSB provider agencies. There were 20 non-CSB QMRs completed (average 3.4 per quarter) during the period from 10/01/2020-06/30/2021. If the number of completed QMRs during these three quarters is reflective of the average number completed per quarter, the frequency of review of non-CSB providers is of concern. Using providers of group home services as an example, there are currently 471 providers of group home services (some of whom are CSBs). If one estimates both that there are 450 non-CSB group home providers and five non-CSB QMRs will be completed each quarter (2 more than the average completed in the three quarters reported), that would be a 4.4% annual sample size (20/450) for non-CSB group home providers. While the overall sample methodology was approved by CMS, based on this specific date range and sample size, the sample size at sample size does not appear to be sufficient to generalize reliable and valid findings whether 95% of DSPs and their supervisors at non-CSB agencies across the Commonwealth receive training and competency testing. Currently, the QMR process does not review evidence of compliance with all required elements of 12VAC30-122-180. For the QMR data to be considered	

Compliance Indicator	Facts	Analysis	Conclusion
		sufficient and reliable, DMAS must be able to provide evidence that the sample selection process includes review of personnel records that are relevant to each of the individual requirements contained in 12VAC30-122-180. For example, the personnel sample must include verification that the provider ensures that a staff member does not work independently prior to completing all of the required training modules and passing the competency test at 80% or higher. The personnel sample must, if the provider serves an individual assigned to Tier IV, include review of relevant training records to assess compliance with the specific requirements set out in 12VAC30-122-180.C that address required advanced core competencies. Additionally, it is of concern that the QMR process does not require review of the provider's training policy(ies) that are relevant to these training requirements nor does it require interview or observation of DSPs/Supervisors to verify the documented competencies that are identified on the Competency Checklist and related DSP and Supervisor assurance statements. Based on review of evidence provided for this study and through interviews with DMAS staff involved in the QMR process, the heavy reliance on document review as the primary method of assessing compliance without concurrent verification of accuracy through interviews with DSPs/DSP Supervisors and other relevant provider staff cannot be determined to be sufficient. DMAS is currently in the process of developing an instruction manual for use by the Health Care Compliance Specialists to guide them in their assessment of compliance with relevant regulations including those at 12VAC30-122-180. They provided a draft of this manual for review but noted its content is not finalized. If the final version of the manual includes appropriate instructions for sampling, evidence gathering related to each of the requirements in 12VAC30-122-180, and verification interviews that assure that the personnel sample will encompass each of the requirements in 12VAC30-122-180, the validity of the data coming from those reviews should be improved. Other parts of this study also identify specific requirements in 12VAC30-122-180 that are not currently being specifically assessed through DMAS's QMR process.	

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49.05: DBHDS makes available for nurses and behavioral interventionists training, online resources, educational newsletters, electronic updates, regional meetings, and technical support that increases their understanding of best practices for people with developmental disabilities, common DD-specific health and behavioral issues and methods to adapt support to address those issues, and the requirements of developmental disability services in Virginia, including development and implementation of individualized service plans.	The Office of Integrated Health (OIH) provides training on a variety of topics relevant to serving the DD population through virtual training sessions and "Falls Prevention" training currently available on the Commonwealth of Virginia Learning Center site. (Documents 98-129, Interviews with OPD and OIH staff) This review also confirmed that OIH publishes a monthly newsletter "Health Trends" that includes health-related feature articles, information on applied behavior analysis, dental health, and announcements of OHI training sessions offered for providers. It also has published online resources including Health and Safety Alerts.	The OIH "Health Trends" newsletter is published monthly and made available to providers through announcements on the DD Listserv. The newsletters are also posted on the OIH page of the DBHDS website and are distributed with the agenda for all monthly Regional Community Nursing meetings. OIH provided 16 virtual training sessions from 01/2021-08/2021. Topic areas and participation levels include: "Fatal 7" – 667 participants (4 sessions); "Skin Integrity" – 234 participants (2 sessions); "Oral Health" – 130 participants (3 sessions); "Sepsis" – 204 participants (1 session); "Wheelchair Transitions" – 180 participants (1 session); "911 and Choking" – 130 participants (1 session); "MRE/DME/AT" – 278 participants (3 sessions); and "Fall Prevention" – 118 participants (1 session). Health & Safety Alert topics published from 01/2021-09/2021 include "Sepsis", "Psychotropic Medications", "Urinary Tract Infections", "Dental Health", "Basic Nutrition", "Dysphagia", "Healthcare Advocacy", and "Grief and Loss". "Falls Prevention" training is currently available on the Commonwealth of Virginia Learning Center (COVLC) site and 252 participants completed this training through the site in 2021. In addition to "Falls Prevention" training, OIH is working to add several training session topics to the Commonwealth of Virginia Learning Center (COVLC) website which will improve ease of access by all provider staff members. Regional Nursing Meetings from January-July, 2021 included continuing education on the following topics: 01/21-Sepsis, 02/21-Psychotropic Medications, 03/21-Urinary Tract Infections, 04/21-Healthcare Advocacy, 05/21-Nutrition, 06/21-Healthcare Advocacy, 07/21-Dental Health Awareness, 08/21-Dysphagia as well as announcements about other training and education opportunities and various health-related information and resources.	17th-Met 19th-Met

Compliance Indicator	Facts	Analysis	Conclusion
	OIH also provides technical assistance to providers relating to a variety of health-related issues upon request or upon referral from other operating areas within DBHDS or DMAS. OIH maintains a tracking log detailing the technical assistance activities they engage in. (Documents 98-113, 128) DBHDS has provided training, general information, and technical assistance to behaviorists on a variety of clinical topics as well as information for providers and support coordinators on how to access behavioral supports and how to bill for those services once provided. This includes specific recommendations to providers from the Special Investigations Unit regarding resources from OIH that can assist	OIH conducts virtual "Regional Community Nursing Meetings" for each region each month. Each meeting includes a health-related topic presentation, review of a nursing continuing education topic (generally on OHI Health Safety Alert topics), announcements of upcoming OIH-sponsored training opportunities, COVID reference materials, and links and other announcements of available resource and reference information for providers. A review of the OIH Technical Assistance Log for the period from 05/01/2021-08/10/2021 included 12 individual technical assistance consultations addressing issues that were identified as care concerns, identifying and reducing health risks, and COVID-related issues. The tracking system is detailed and provides clear evidence of the types of technical assistance provided as well as follow-up activities that may be needed as a result of the specific technical assistance. The DBHDS Special Investigations Unit conducts investigations of deaths and serious incidents in licensed provider organizations. They utilize resources from the Office of Integrated Health frequently in conducting their investigations and encourage providers to utilize these same resources to develop and implement effective corrective action plans for cited non-compliance. DBHDS has published five educational articles on behavioral services including: (1) What to Expect from "Problem Focused" Behavioral Services, (2) Data Collection is Pivotal for Progress, (3) Indications for the Use of Indirect FBA Procedures, (4) Behavioral Skills Training Improves Behavior Support Plan Implementation, and (5) Scope of Practice v. Scope of Competence. In September 2021, DBHDS published a Health & Safety Alert on Grief and Loss. They have also participated with the Virginia Association for Behavior Analysis in a survey of clinicians and used information from the survey to inform additional training needs planning. Information on Behavioral Supports was a primary topic in the February Provider/Support Coordinator Roundtable meeting with 500 registrants participating.	

Compliance Indicator	Facts	Analysis	Conclusion
	them in developing and implementing effective corrective action plans. (Documents 123-124, 128-129) DBHDS published a set of *Practice Guidelines* for behavioral supports which was released in final form in August, 2021. (Document 130)	DBHDS has also provided technical support to behaviorists including information on appropriate graphical displays for the service, operational definitions of behavior and measurement systems/data collection, and functional behavioral assessment and function-based treatment. A set of *Practice Guidelines* for behavioral supports was published in final form in August, 2021 and a notice was sent to providers through the Listserv. Training related to the *Practice Guidelines* has also been added to the Commonwealth of Virginia Learning Center (COVLC) site. The 11 providers selected for onsite interviews for this study were each aware of these resources being made available by DBHDS. While noting awareness of availability of these resources, none of the providers interviewed indicated that they had used the resources often. The impact of COVID restrictions and the resulting staffing shortages that all of the providers in the sample have been and are currently experiencing has also been a limiting factor in using these resources. Six of the eleven providers interviewed also expressed significant frustration with the difficulties they experienced in locating and accessing information on the DBHDS website. Complaints from sample providers centered on difficulty finding needed reference information, a lack of intuitive organization of the information, the requirement to mine through many layers of sub-menus to locate a specific topic or piece of information, frequent disconnected links that prove to be a dead-end for the specific information being sought, and the currency of some of the information contained on the website. Based on review of evidence and interviews with DBHDS staff and 11 providers, DBHDS has continued to develop and expand training, online resources, educational newsletters, electronic updates, regional meetings and technical support for nurses and behaviorists.	
49.06: Employers and contractors responsible for providing	DMAS transportation fee-for-service and managed care contract requirements are	DMAS is responsible for administering Virginia Medicaid's Fee-For-Service (FFS) Emergency Ambulance and Non-Emergency Medicaid Transportation (NEMT) services. DMAS FFS transportation services include Emergency Air, Emergency Ground, Neonatal Ambulance and NEMT services. The FFS Non-	17th-Met 19th-Met

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transportation will meet the training requirements established in the DMAS transportation fee for service and managed care contracts. Failure to provide transportation in accordance with the contracts may result in liquidated damages, corrective action plans, or termination of the vendor contracts.	established in the "VA Transportation Provider Agreement 2021" between Modivcare Solutions, LLC and the contracted transportation provider agency. (Document 132) Non-emergency medical transportation requirements are detailed in the "DMAS Fee-for-Service Non-Emergency Medical Transportation Driver, Attendant, and Vehicle Requirements" document most recently revised on 03/05/2021. The contents of this document are incorporated into the provider agreement between Modivcare and each transportation vendor by reference. (Document 135) The Driver, Attendant, and Vehicle Requirements document states that all drivers,	Emergency Medicaid Transportation service is managed and operated by the statewide contracted transportation broker, Modivcare Solutions, LLC. The contractual framework including the requirement for completion of Passenger Services and Safety (PASS) training and certification for all drivers prior to transporting any individual establishes detailed transportation provider requirements for driver training. A multi-level quality assurance review process is in place that includes measurement of compliance with all driver training requirements. Modivcare conducts quality assurance reviews of each transportation provider that include assuring that all drivers are PASS certified. The Provider Agreement contains provisions for Liquidated Damages in specified circumstances and Exhibit A of the Agreement establishes parameters for imposition of liquidated damages. The DMAS Transportation Medical Support Unit (TMSU) conducts field monitoring of the transportation providers contracted with Modivcare. These audits also include whether drivers received required training and PASS certification. For SFY2020 TMSU withheld $319,500 in the SLAs for performance issues in the following categories – Accident/Incident ($25,000); Hospital Discharge ($90,000); Unfulfilled Trips ($125,000); Call Center Wait Time ($75,000); Vehicle Safety ($4,500). Recoupments specific to provider training non-compliance are a part of these totals but are not specifically broken out. During Quarters 1 and 2 of FY2021, no liquidated damages were imposed. The transportation system was significantly impacted by the COVID-19 pandemic. Processes and procedures were modified including some provisions that related to driver training, most specifically the allowance for virtual training for all areas except wheelchair safety which continued to require in-person instruction and testing due to the nature of the training content.	

Compliance Indicator	Facts	Analysis	Conclusion
	attendants, taxi drivers, and volunteer drivers must pass a Passenger Service and Safety (PASS) Trainer and Driver Course before transporting any member. It establishes additional training requirements for drivers and attendants providing transportation via Stretcher Van and a requirement for the Contractor to conduct driver attendant credentialing reviews at least annually. (Document 135) Quality assurance reviews of transportation providers are performed by Modivcare (formerly LogistiCare) and by the DMAS Transportation Management Services Unit (TMSU) and identified violations or deficiencies may result in liquidated damages being imposed. (Document 136 and interview with	Documentary evidence and information gathered through interviews supports that DMAS has written requirements to assure that employers and contractors responsible for providing transportation meet the training requirements established in the DMAS transportation fee for service and managed care contracts. Quality assurance and oversight procedures are in place to evaluate compliance and a process to impose sanctions on providers who are not compliant with the requirements is in place and operational.	

Compliance Indicator	Facts	Analysis	Conclusion
	Transportation Unit staff)		
49.07: The DBHDS Office of Integrated Health provides consultation and education specific to serving the DD population to community nurses, including resources for ongoing learning and development opportunities.	OIH provides education on a variety of topics relevant to serving the DD population through Regional Community Nursing Meetings, virtual training sessions, Health and Safety Alerts, and "Falls Prevention" training currently available on the Commonwealth of Virginia Learning Center site. (Documents 137-161) OIH provides consultation and technical assistance to providers upon request or upon referral from other operating areas within DBHDS or DMAS. OIH maintains a tracking log detailing the technical assistance activities they engage in. (Documents 162-164)	The Office of Integrated Health (OIH) conducts virtual "Regional Community Nursing Meetings" for each region each month. Each meeting includes a health-related topic presentation, review of a nursing continuing education topic (generally on OIH Health Safety Alert topics), announcements of upcoming OIH-sponsored training opportunities, COVID reference materials, and links and other announcements of available resource and reference information for providers. Specific presentation topics at the Regional Nursing meetings held from 01/2021-08/2021 include "Smoking Cessation", "What Behaviorists Do & Crisis Intervention", What Regional Community Resource Consultants (CRCs) Do", "Nutrition", "Available Resources from the Eunice Kennedy Shriver Center", "Dental Services offered by OIH" and "Positioning to Decrease the Risk of Dysphagia". OIH provided 16 virtual training sessions from 01/2021-08/2021. Topic areas and participation levels include: "Fatal 7" – 667 participants (4 sessions); "Skin Integrity" – 234 participants (2 sessions); "Oral Health" – 130 participants (3 sessions); "Sepsis" – 204 participants (1 session); "Wheelchair Transitions" – 180 participants (1 session); "911 and Choking" – 130 participants (1 session); "MRE/DME/AT" – 278 participants (3 sessions); and "Fall Prevention" – 118 participants (1 session). "Falls Prevention" training is currently available on the Commonwealth of Virginia Learning Center (COVLC) site and 252 participants completed this training through the site in 2021. In addition to "Falls Prevention" training, "The Importance of Calling 911" training was added to this site in September. OIH is working to add several additional training session topics to the site which will provide convenient access by all caregivers and staff members.	17th-Met 19th-Met

Compliance Indicator	Facts	Analysis	Conclusion
		The Mortality Review Committee reports to the Commissioner for Q1-2021 and Q2-2021 contained two references to specific consultations that occurred with provider staff relevant to issues identified from several mortality reviews including opiate overdose procedures and procedures for suctioning and administering congestion medications. A review of the OIH Technical Assistance Log for the period from 05/01/2021-08/10/2021 included 12 individual technical assistance consultations addressing issues that were identified as care concerns, identifying and reducing health risks, and COVID-related issues. The tracking system is detailed and provides clear evidence of the types of technical assistance provided as well as follow-up activities that may be needed as a result of the specific technical assistance. Providers interviewed for this study each indicated an awareness of educational resources but seemed less aware of consultation and technical assistance available from DBHDS. Several noted they had local or area resources that they used more frequently for consultation and technical assistance when it was needed. DBHDS continues to provide and has expanded opportunities for providers to access consultation and education specific to serving the DD population to community nurses and other provider staff.	
49.08: Per DBHDS Licensing Regulations, DBHDS licensed providers, their new employees, contractors, volunteers, and students shall be oriented commensurate with their function or job-specific responsibilities within	12VAC35-105-30 establishes the requirement for licensure for specific provider types. (Document 165) 12VAC35-105-440 requires that new employees, contractors,	Provider agencies that require licensure for operations are identified at 12VAC35-105-30. The requirements of this Compliance Indicator for licensed providers are laid out specifically in licensing regulations at 12VAC35-105-440 which became effective 12/07/2011. The OL Annual Checklist Compliance Determination Chart – FY2021 (rev 4/29/21) provides specific instructions to the licensing specialist on what and how to assess compliance with 12VAC35-105-440. It lists each of the nine requirements and instructs DBHDS Licensing Specialists to review the	17th-Met 19th -Met

Compliance Indicator	Facts	Analysis	Conclusion
15 business days. The provider shall document that the orientation covers each of the following policies, procedures, and practices: a. Objectives and philosophy of the provider; b. Practices of confidentiality including access, duplication, and dissemination of any portion of an individual's record; c. Practices that assure an individual's rights including orientation to human rights regulations; d. Applicable personnel policies; e. Emergency preparedness procedures; f. Person-centeredness; g. Infection control practices and measures; h. Other policies and procedures that apply to specific positions and specific duties and responsibilities; and i. Serious incident reporting, including when, how, and under what circumstances a serious incident report must	volunteers, and students shall be oriented commensurate with their function or job-specific responsibilities within 15 business days and that the provider shall document that the orientation covers each of the nine required elements specified in this Compliance Indicator. (Document 166) Licensing specialists have detailed instructions that guide them in their assessment of compliance with this regulation. (Document 167) Reviewer's Note: This review determined that the nine licensed providers in the sample each had a policy that outlined the requirements for this training consistent with the content of this Compliance Indicator. Each was also able to	documentary evidence of new employee orientation to verify it was completed within 15 business days of hire. It also instructs Licensing Specialists to cite this regulation as non-compliant if any component of the orientation is missing. Only nine of the 11 agencies in the sample required a license for their services. Review of the provider training policies for each of the nine providers noted inclusion of required elements for employee orientation with a few noted exceptions. In further review of those exceptions, the provider addressed that specific training requirement for employee orientation in another policy. In these instances, the providers were encouraged to ensure inclusion of all nine of the required elements in their employee training policy. Each of the providers in the sample were able to fully describe their orientation process and were able to show evidence of how they document the training provided. Licensing Specialists interviewed for the study each confirmed that they reviewed the content of the provider's training policy(ies) to measure compliance with the requirements at 12VAC35-105-440. My review of the provider training policies for the sample agencies identified similar findings regarding compliance with the training requirements at 12VAC35-105-440 to those made by the licensing specialist. Documentary evidence and interviews with DBHDS staff and nine providers verified that regulations require licensed providers, their new employees, contractors, volunteers, and students shall be oriented commensurate with their function or job-specific responsibilities within 15 business days. Evidence from review of nine provider training policies and interviews with representatives of each of these provider organizations confirmed they were following this regulatory requirement in their individual operations.	

Compliance Indicator	Facts	Analysis	Conclusion
be submitted and the consequences of failing to report a serious incident to the department in accordance with the Licensing Regulations.	produce documentary evidence that their employee orientation training covered each of the required topics and that it was conducted within the first 15 days of employment. (Document 170)		
49.09: The Commonwealth requires through the DBHDS Licensing Regulations specific to DBHDS-licensed providers that all employees or contractors who are responsible for implementing an individual's ISP demonstrate a working knowledge of the objectives and strategies contained in each individual's current ISP, including an individual's detailed health and safety protocols.	The regulation 12VAC35-105-665.D requires that "Employees or contractors who are responsible for implementing the ISP shall demonstrate a working knowledge of the objectives and strategies contained in the individual's current ISP, including an individual's detailed health and safety protocols." (Document 171) The OL Annual Checklist Compliance Determination Chart – FY2021 (rev 4/29/21) at 12VAC35-105-665.D instructs DBHDS	The licensing regulation at 12VAC35-105-665.D became effective 12/07/2011. This regulation contains specific requirements that persons responsible for implementing an individual's ISP must "demonstrate a working knowledge of the objectives and strategies contained in the individual's current ISP, including an individual's detailed health and safety protocols." The ability of Licensing Specialists to conduct a thorough determination of compliance with this requirement was limited during the period from March 2020-March 2021 when onsite inspections were not possible due to statewide COVID-19 restrictions. Due to these restrictions, DBHDS Licensing Specialists conducted all annual licensing inspections remotely during that period. On 04/01/2021, Licensing Specialists began conducting some annual licensing inspections face-to-face with full implementation of face-to-face inspections dependent on several factors relating to the evolving COVID-19 situation, incident reports of provider outbreaks, and/or additional data from the Virginia Department of Health and the Centers for Disease Control and Prevention. The DBHDS Office of Licensing sent a memo to all providers dated 05/28/2021 that addressed services for individuals with developmental disabilities with high-risk health conditions. In this memo, providers were reminded of the requirements to assure that staff can demonstrate a working knowledge of the ISP Supports and that staff be trained on the ISP and specific durable medical equipment/assistive technology/adaptive equipment protocols by specialists.	17th-Met 19th-Met

Compliance Indicator	Facts	Analysis	Conclusion
	Licensing Specialists to review assessments for each individual in the sample and to identify if documentary evidence of the required staff training on the ISP, including health and safety protocols. (Document 172) Competency 2 on the DSP Competencies Checklist contains four specific competencies relating the purpose, content, and implementation procedures for the ISP. These competencies must be demonstrated by DSPs as a part of the Competency / Proficiency determination process. (Document 173) Licensing Specialists review the ISP for each individual in their sample and interview DSPs/Supervisors, as needed, to confirm their	Licensing Specialists interviewed as part of this study were each able to correctly describe the procedures they follow to review the ISPs for each individual in the sample. They further stated that individuals with a history of care concerns, reportable incidents, with behavior support plans, and/or with complex health conditions are generally included in the sample to assure a thorough review of the regulations that relate to knowledge of the objectives and strategies contained in each individual's current ISP. Each noted that they observe DSPs and conduct interviews with DSPs, as needed, during the course of their annual inspection. Each Licensing Specialist interviewed was able to correctly identify specific examples of health and safety protocols that they evaluate as part of their inspection. Licensed providers interviewed as a part of this study each had written policy/procedure statements that relate to the development and implementation of the ISP for each individual served including procedures for training of each staff member responsible for implementation of the ISP. Providers also confirmed that there was a detailed review of the ISP, including records of staff being trained in the ISP content, during each annual licensing inspection. Documentary evidence and information gained through interviews for this study confirmed that licensing regulations at 12VAC35-105-665.D require that all employees or contractors of licensed provider agencies who are responsible for implementing an individual's ISP demonstrate a working knowledge of the objectives and strategies contained in each individual's current ISP, including an individual's detailed health and safety protocols and that providers are assessed for compliance with this requirement during each annual licensing inspection.	

Compliance Indicator	Facts	Analysis	Conclusion
	knowledge of the ISP content and how to carry out its requirements. (Document 172 and interviews with licensing specialists) Each licensed provider in the sample described their ISP training process and each uses the ISP as the primary teaching tool to orient employees on the ISP content and appropriate methods to implement its content. (Interviews with staff from nine licensed providers in the sample)		
49.10: The Commonwealth requires all employees or contractors without clinical licenses who will be responsible for medication administration to demonstrate competency of this set of skills under direct observation prior to performing this task without direct supervision.	12VAC30-122-120.A.20 (effective 03/31/2021) states that "Providers shall ensure that all employees or contractors without pertinent or medical clinical licenses who will be responsible for medication administration demonstrate competency of this set of skills under direct observation prior	The DMAS regulation at 12VAC30-122-120.A.20 establishes a regulatory requirement that addresses this Compliance Indicator. Through interviews with DMAS administrative and Health Care Compliance Specialists, each confirmed that DMAS does not assess compliance with this regulatory requirement in the QMR process. These staff further stated that regulatory compliance with the requirement that medications can only be administered by staff who have completed the required 32-hour training/certification course is assessed by DBHDS Office of Licensing. The DBHDS Licensing regulation at 12VAC35-105-770 includes two sections relevant to this compliance indicator. §A.4 states that "The provider shall implement written policies addressing employees or contractors who are authorized to administer medication and training required for administration of	17th-Not Met 19th-Met

Compliance Indicator	Facts	Analysis	Conclusion
	to performing these tasks with any individual service recipient." Reviewer's Note: DMAS staff confirmed that they do not assess compliance with this DMAS regulation in the QMR process. (Document 178, interviews with DMAS staff) Certification of unlicensed individuals to administer medications is governed by 18-VAC90-21-30 & 40 (Virginia Board of Nursing) which requires that any unlicensed individual who administers medications must first successfully complete a 32-hour DBHDS approved training program and pass a written and practical examination that measures minimum competency in medication administration. (Document 179)	medication." §B states that "Medications shall be administered only by persons who are authorized to do so by state law." Neither of these requirements specifically state the requirement that the staff member must "demonstrate competency of this set of skills under direct observation prior to performing the task without supervision"; however, the approved DBHDS 32-hour medication aid training does require competency assessment and demonstration of competency to administer medications. Licensing regulations also specify at 12VAC35-105-450 that the provider's policy must include the frequency by which medication administration refresher training must be completed by each staff member who administers medications. The Competency Checklist includes, under Competency 3, "Conveys an understanding of the steps needed to ensure medications are provided as prescribed to include providing medications or contacting qualified staff who can provide medications." Based on this identified competency under Competency 3, the employee must be determined "competent" prior to working in the absence of staff who have been determined proficient in this area. Only eight of the 11 providers in the sample allow their DSPs to administer medications. Two of those who do not allow DSPs to administer medications do not require a DBHDS license for their operations. Each of the eight providers whose DSPs administer medications have a policy that addresses the requirement for successful completion of the 32-hour medication administration training and a requirement for at least annual refresher training. Each of these providers also stated that it is their general practice to assure this training is completed within the first 15 days of employment given most DSPs are responsible for administering medications and cannot do so until the training is completed and their competency verified. DBHDS Licensing Specialists interviewed confirmed that they assess provider compliance with the medication administration certification and administration procedures and licensing requirements at 12VAC35-105-450, 770 and 790.	

Compliance Indicator	Facts	Analysis	Conclusion
	12VAC35-105-770 "Medication Management" and 12VAC35-105-790 "Medication Administration and Storage or Pharmacy Operation" address or relate to the requirement for completion of a DBHDS approved 32-hour certification course required by the Virginia Board of Nursing. Licensing Specialists interviewed confirmed that they evaluate the provider's compliance with these regulations as part of the annual licensing inspection. (Documents 180 & 181 and interviews with Licensing Specialists) 12VAC35-105-450 requires that the provider identify the frequency of retraining on medication administration in their provider training policy.	In summary, regulations relevant to this compliance indicator can be found in 12VAC30-122-120.A.20 (DMAS Regulation) and at 12VAC35-105-450, 770 and 790 (DBHDS Regulations). DMAS does not assess provider compliance with their relevant regulation in the QMR process. DBHDS Licensing assesses compliance with all three of their relevant regulatory requirements during annual licensing inspections. That assessment of compliance by Licensing appears sufficient to demonstrate that the Commonwealth is meeting the requirements of this Compliance Indicator.	

Compliance Indicator	Facts	Analysis	Conclusion
	Reviewer's Note: This was consistently found to be present in the policy statements for the sample provider organizations and the providers were able to describe the specific method and timeline for completing this training within their organization. (Document 182, interviews with licensed providers)		
49.11: The Commonwealth requires all employees or contractors of DBHDS-licensed providers who will be responsible for performing de-escalation and/or behavioral interventions to demonstrate competency of this set of skills under direct observation prior to performing these tasks with any individual service recipient.	DMAS has a regulatory requirement with wording identical to the Compliance Indicator. This regulation is found at 12VAC30-122-120.A.21 (effective 03/31/2021). (Document 189) DBHDS has a licensing regulation relevant to this indicator at 12VAC35-105-810 (effective 12/07/2011). (Document 190)	The DMAS regulation at 12VAC30-122-120.A.21 establishes a regulatory requirement with wording identical to the wording in this Compliance Indicator. The DBHDS licensing regulation at 12VAC35-105-810 (effective 12/07/2011) requires that providers ensure behavior treatment plans are "developed, implemented, and monitored by employees or contractors trained in behavioral treatment." The DBHDS Human Rights regulation at 12VAC35-115-110.C.10 establishes a requirement that providers must "ensure that only staff who have been trained in the proper and safe use of seclusion, restraint, and time out techniques may initiate, monitor, and discontinue their use." Based on verification of these regulatory requirements, **there is sufficient evidence to support that the Commonwealth is meeting the requirements of this Compliance Indicator.**	17th-Not Met 19th-Met

Compliance Indicator	Facts	Analysis	Conclusion
	DBHDS has a Human Rights regulation relevant to this indicator at 12VAC35-115-110.C.10 (effective 02/09/2017).	Reviewer's Note: The monitoring process utilized in the annual licensing inspection is evaluated at Compliance Indicator 49.02. Licensing Specialists assess compliance with the requirements at 12VAC35-105-810 during the annual licensing inspection. To determine compliance, the Licensing Specialist reviews whether each DSP/Supervisor has successfully completed the proprietary training (TOVA, CPI, CIT, etc.) specified in the provider's training policy. In addition, Licensing Specialists are instructed to ensure inclusion of an individual with a BSP if one or more individuals has one. If the individual has a BSP, the Licensing Specialist reviews relevant records of staff training to ensure each of the DSPs/Supervisors responsible for implementing the ISP has been trained on the specific requirements in that BSP and, if needed, the Licensing Specialist interviews the DSP/Supervisor to verify knowledge of the BSP requirements. When asked, providers in the sample stated they meet this requirement by training all DSPs/Supervisors using one of several proprietary instructional tools which includes non-individual specific training on performing de-escalation and/or behavioral interventions. Examples of proprietary training programs identified by providers and Licensing Specialists in the sample include Therapeutic Options of Virginia (TOVA), Crisis Prevention Institute (CPI) Training, and Crisis Intervention Training (CIT). Each of these training curricula includes instructional training as well as competency certification under the direction of a certified trainer. Providers stated that each DSP and DSP Supervisor also receives specific training on the content and requirements of an individual's BSP is one has been prescribed.	
49.12: At least 86% of DBHDS licensed providers receiving an annual inspection have a training policy meeting established DBHDS requirements for staff training, including	12VAC35-105-450 establishes the regulatory requirement for licensed providers to have a training policy that includes all required elements outlined in this	12VAC35-105-450 (effective 12/07/2011) states that "The provider shall provide training and development opportunities for employees to enable them to support the individuals receiving services and to carry out their job responsibilities and their training policy must specify the frequency of retraining on serious incident reporting, medication administration, behavior intervention, emergency preparedness, and infection control, to include flu epidemics.	17th-Not Met 19th-Not Met

Compliance Indicator	Facts	Analysis	Conclusion
development opportunities for employees to enable them to support the individuals receiving services and to carry out their job responsibilities. These required training policies will address the frequency of retraining on serious incident reporting, medication administration, behavior intervention, emergency preparedness, and infection control, to include flu epidemics. Employee participation in training and development opportunities shall be documented and accessible to the department. DBHDS will take appropriate in action in accordance with Licensing Regulations if providers fail to comply with training requirements required by regulation.	Compliance Indicator. (Document 196) 12VAC35-105-50, 100, 110, and 115 prescribe negative actions and sanctions that can be taken with providers with significant or re-occurring citations. (Document 197) The OL Annual Checklist Compliance Determination Chart-FY2021 includes review of the provider's training policy and verification that the policy addresses the relevant content of their required employee training and the frequency of retraining on serious incident reporting, medication administration, behavior intervention, emergency preparedness, and infection control, to include flu epidemics. (Document 199 and interviews with DBHDS licensing specialists)	The OL Annual Checklist Compliance Determination Chart-FY2021 provides detailed guidance to Licensing Specialists on how to assess compliance through review of the provider's training policy to ensure it contains all of the required elements and review of training records to verify that each DSP/Supervisor in the sample has documentation of the required training. Licensing Specialists interviewed for this study described the procedures they follow to assess compliance with this requirement. I reviewed training policies for each of the nine licensed providers in the sample and found that their policy statements consistently included the required elements. If a specific element was not referenced in the training policy, I inquired and verified that it was addressed in another of the provider's policy statements. My findings concurred with those of the licensing specialist who completed the provider's most recent annual licensing inspection. The Office of Licensing has the ability to impose negative actions and sanctions that can be taken with providers with significant or re-occurring citations. These actions are detailed at 12VAC35-105-50, 100, 110, and 115. Actions include issuance of a provisional license, summary suspension, denial of license renewal, revocation of a license, and sanctions (probation, fees, mandatory training, suspension, civil penalties, etc. DBHDS was requested to provide a list of enforcement actions that have been taken for licensing violations requiring action beyond a CAP but did not provide that requested information. While evidence of the requirements and process to review provider compliance with 12VAC35-105-450 was provided and interviews with licensing specialists, review of provider training policies, and interviews with sample providers demonstrated evidence that compliance with this requirement is assessed during annual licensing inspections, DBHDS did not provide data to demonstrate compliance with the 86% threshold requirement in this Compliance Indicator. Because no data was provided for review, it was not possible to assess whether the Commonwealth Met this Indicator.	

Compliance Indicator	Facts	Analysis	Conclusion
	DBHDS has defined regulatory enforcement action options to address identified serious non-identified non-compliance, patterns of non-compliance, and/or non-compliance that is identified repeatedly. (Document 202) DBHDS did not provide data related to their review and determination of compliance with 12VAC35-105-450 from annual licensing inspections. For that reason, it was not possible to assess compliance with the 86% threshold requirement in this Compliance Indicator.		
49.13: Consistent with CMS assurances, DBHDS, in conjunction with DMAS QMR staff, reviews citations (including those related to staff qualifications and	Waiver Assurances for the Building Independence, Family & Individual Supports, and Community Living waivers state that the DBHDS Office of	This review verified that the DBHDS Community Resource Consultants (CRCs) receive results of each QMR completed by DMAS. The CRC reviews information from these reports and identifies common themes of identified non-compliance and areas of significant concern for service provision. Based on a review of the agendas and interviews with providers, the issues identified from their reviews, the CRC prepares a presentation for each Quarterly Regional Support Coordinator / Case Manager and Provider Roundtable meeting to	17th-Met 19th-Met

Compliance Indicator	Facts	Analysis	Conclusion
competencies) and makes results available to providers through quarterly provider roundtables.	Licensing verifies that providers meet DBHDS licensing standards and that the DMAS Quality Management Review (QMR) verifies that provider staff have received the required training. They further state that DBHDS and DMAS, in their respective regulatory roles, are responsible for oversight and improvement of the quality of services delivered under the DD waivers. (Documents 210-212) An analysis of results from the DMAS QMR process is presented as a standing item in each quarterly Regional Support Coordinator/Case Manager and Provider Roundtable meeting. (Document 203-209)	include common themes of citations, examples of areas of non-compliance, and successful methods of provider address of non-compliance. Representatives from DBHDS and DMAS also meet prior to development of the Quarterly Regional Support Coordinator/Case Manager and Provider Roundtable meeting agendas to identify any information relevant to providers referenced in the QMR review process. The agendas reviewer for this study also confirmed that these items are also added to the agenda for each of the Quarterly Regional Support Coordinator / Case Management and Provider Roundtable meetings. Presentations of information from each of the sources identified above are included as a standing item on each provider roundtable agenda. A review of the agendas and handouts for the most recent three quarterly meetings confirmed that these presentations were made in each of the meetings. The presentations included analysis and identification of trends/patterns of citations for all DMAS regulatory requirements including those that relate to staff qualifications and competencies. Each of the 11 providers interviewed in the sample for this study identified the Quarterly Regional Support Coordinator / Case Manager and Provider Roundtable meetings as very beneficial and each stated they participate in these meetings frequently. Several of the providers interviewed suggested consideration be given to increasing the frequency of these meetings from quarterly to every two months given the volume of helpful information that is shared in each. Based on review of documentary evidence, interviews with DMAS and DBHDS staff, and interviews with 11 providers, there is a review and analysis process for QMR data to be presented and there are presentations related to this data in each of the Quarterly Provider Roundtable meetings. Consideration should be given to adding information in these presentations about relevant trends and patterns of findings from the annual licensing inspections as this would also be	

Compliance Indicator	Facts	Analysis	Conclusion
		helpful to providers to identify potential areas of concern in their operations prior to them being identified through the annual licensing inspection.	
50.01: DSP Supervisors are responsible for adequate coaching and supervision of their staff trainees. As part of its training program, DBHDS will develop and make available a supervisory training for all DSP supervisors who are required to complete DSP training and testing per DMAS Waiver Regulations in DBHDS-licensed and non-DBHDS-licensed agencies as described in DMAS Waiver Regulations.	12VAC30-122-180 requires DSPs and DSP Supervisors to complete a DMAS-approved orientation training (§A.1) and pass a DMAS-approved objective, standardized test of knowledge, skills and abilities at 80% or higher (§A2). (Document 214) DBHDS Provider Development developed and implemented a 3-module online training curriculum for supervisors on 07/01/2020. The training is accessed through the Commonwealth of Virginia Learning Center (COVLC). Upon completion of the required supervisory training modules, supervisors receive a certificate of completion that serves as documentary proof of	This review verified that the DBHDS Provider Development launched an expanded 3-module online training curriculum for supervisors on 07/01/2020. The training is accessed through the Commonwealth of Virginia Learning Center (COVLC). The training addresses supervisors' responsibilities for ensuring DSP training, testing, and competency requirements of each of the three waivers. Topics in the training include (1) skills needed to be a successful supervisor, (2) organizing work activities; (3) the supervisor's role in delegation; (4) common motivators and preventive management; (5) qualities of effective coaches; (6) employee management and engagement; (7) stress management; (8) conflict management; (9) the supervisor's role in minimizing risk; (10) mandated reporting; and (11) CMS-defined requirements for the ISP planning process and the resulting ISP. Upon completion of the required supervisory training modules, supervisors receive a certificate of completion that serves as documentary proof of course completion and successful passing of the competency testing. The DMAS QMR process includes review of the certificate of completion as evidence that the supervisor has received training and successfully completed the competency assessment. This review confirmed that nine of the 11 providers in the sample stated they were aware of the supervisory training and require the training as part of their training program. The two providers who stated they were not aware and don't currently require this supervisory training were home health agencies that provide agency-directed personal attendant services. In their most recent QMR, one was cited for non-compliance under existing waiver authority noting that there was no documentation that one supervisor had completed the DSP Supervisor Orientation Training. The second agency that stated they were not aware of and did not require this training was not cited in their most recent QMR. The Provider Data Summary Semi-Annual Report for the period 11/01/2020-04/30/2021 stated that 295 supervisors had successfully completed the revised	17th-Met 19th-Met

Compliance Indicator	Facts	Analysis	Conclusion
	course completion and successful passing of the Orientation Manual test with a score of 80% or higher. (Documents 218-221, interviews with Office of Provider Development Director)	supervisory training. Currently, DBHDS does not have specific data or an estimate of how many DSP Supervisors are working in the system and therefore cannot project what percentage of the total number of DSP supervisors in the system have completed the required training. Review of documentary evidence, interviews with DMAS and DBHDS staff, and interviews with 11 sample providers identified evidence that DBHDS has developed and made available a supervisory training for all DSP supervisors who are required to complete DSP training and testing per DMAS Waiver Regulations in DBHDS-licensed and non-DBHDS-licensed agencies as described in DMAS Waiver Regulations. DBHDS continues to evaluate and expand this training based on feedback from providers.	
50.02: DBHDS will develop and make available a supervisory training for all DSP supervisors who are required to complete DSP training and testing per DMAS Waiver Regulations in DBHDS-licensed and non-DBHDS-licensed agencies as described in DMAS Waiver Regulations. At a minimum, this training shall include the following topics: a. skills needed to be a successful supervisor; b. organizing work activities; c. the supervisor's role in delegation;	12VAC30-122-180 requires DSPs and DSP Supervisors to complete a DMAS-approved orientation training (§A.1) and pass a DMAS-approved objective, standardized test of knowledge, skills and abilities at 80% or higher (§A2). (Document 228) The 3-module online training curriculum for supervisors that is accessed through the Commonwealth of Virginia Learning Center (COVLC) addresses each of the	DBHDS Provider Development launched an expanded 3-module online training curriculum for supervisors on 07/01/2020. This review verified that the training is accessed through the Commonwealth of Virginia Learning Center (COVLC). The expanded training addresses supervisors' responsibilities for ensuring DSP training, testing, and competency requirements and contains information on each of the elements required by this compliance indicator including (a) skills needed to be a successful supervisor; (b) organizing work activities; (c) the supervisor's role in delegation; (d) common motivators and preventive management; (e) qualities of effective coaches; (f) employee management and engagement; (g) stress management; (h) conflict management; (i) the supervisor's role in minimizing risk (e.g., health-related, interpersonal, and environmental); (j) mandated reporting; and (k) CMS-defined requirements for the planning process and the resulting plan. Nine of 11 providers in the sample stated they believed the supervisory training was beneficial. Several suggested that it would be helpful to incorporate more training for supervisors who work in very small organizations who are responsible to carry out multiple varied responsibilities including providing direct supports during the majority of their work time.	17th-Met 19th-Met

Compliance Indicator	Facts	Analysis	Conclusion
d. common motivators and preventive management; e. qualities of effective coaches; f. employee management and engagement; g. stress management; h. conflict management; i. the supervisor's role in minimizing risk (e.g., health-related, interpersonal, and environmental); j. mandated reporting; and k. CMS-defined requirements for the planning process and the resulting plan.	elements required by this compliance indicator (a-k). (Documents 218-220) The training curriculum includes each of the 11 required elements outlined in this Compliance Indicator. (Documents 218-220)	This study's review of documentary evidence, interviews with DMAS and DBHDS staff, and interviews with 11 sample providers identified evidence that DBHDS has developed and made available a supervisory training for all DSP supervisors who are required to complete DSP training and testing per DMAS Waiver Regulations in DBHDS-licensed and non-DBHDS-licensed agencies as described in DMAS Waiver Regulations. Additionally, this reviewer verified that the training includes each of the 11 required elements outlined in this Compliance Indicator. DBHDS continues to evaluate and expand this training based on feedback from providers.	
50.03: In addition to training and education, support and coaching is made available to DBHDS-licensed providers through the DBHDS Offices of Integrated Health and Provider Development upon request and through community nursing meetings, provider roundtables, and quarterly support coordinator meetings to increase the knowledge and skills of staff and supervisors providing waiver services. DBHDS will	DBHDS provides training, education, support, and coaching through activities within the Office of Provider Development (OPD) and the Office of Integrated Health (OIH). OPD operationally defines support and coaching as presenting opportunities to discuss an individual's, provider's, support coordinator's, or agency's unique	This review verified that the Office of Provider Development (OPD) has three primary focus areas in its operations – individual, provider, and system. Support and coaching activities are provided at each of these levels and differ somewhat in their focus. At the individual level, support and coaching includes providing requested assistance with programmatic changes within individual agencies to enable them to operate more consistently within the structure and requirements of the Virginia HCBS waivers. At the provider level, support and coaching is focused on the organization and includes guidance on policy development, process development/refinement, ISP implementation, etc. At the system level, support and coaching most often occurs through discussions with support coordinators about topics including practical methods to explore community options, ensuring rights and choice, etc. OPD and OIH provide training and education through quarterly provider roundtable meetings, quarterly support coordinator meetings, and monthly community nursing meetings. Information from minutes and question/answer	17th-Met 19th-Met

Compliance Indicator	Facts	Analysis	Conclusion
compile available support and coaching resources that have been reviewed and approved for placement online and ensure that DBHDS-licensed providers are aware of these resources and how to access them.	circumstances and to assist these entities to develop workable solutions to meet their unique needs. (Documents 239-271, and interviews with the OPD Director and OIH Director) Training and education activities include topics that have broad application across provider organizations and are most often presented through virtual or regional trainings, monthly and quarterly provider meetings, etc. (Documents 239-271, and interviews with the OPD Director and OIH Director) DBHDS has implemented a Centralized Training for Providers website that contains required training, recommended training, and resources	documents from the provider roundtable and support coordinator meetings summarize presentations on a variety of topic areas relevant to provision of waiver services. Training and education activities also include monthly virtual Regional Nursing Meetings. From January-July, 2021 presentations in these meetings addressed the following topics: 01/21-Sepsis, 02/21-Psychotropic Medications, 03/21-Urinary Tract Infections, 04/21-Healthcare Advocacy, 05/21-Nutrition, 06/21-Healthcare Advocacy, 07/21-Dental Health Awareness, 08/21-Dysphagia as well as announcements about other training and education opportunities and various health-related information and resources. This DBHDS Centralized Provider Training webpage contains training resources for waiver services providers. This site includes training options that can be accessed or are linked to other websites. It provides information regarding required training, recommended training, and resources to assist providers in a variety of operational and service delivery areas. The Required Training section includes training resources that meet various regulations or requirements for DD Waiver service providers. This list is not designed to be all-inclusive but provides a useful resource for providers to assist them in finding information on regulations and policies that affect them. The content is reviewed and updated periodically to assure it remains current and accurate. Providers interviewed in the sample indicated their awareness of these resources but noted that significant staffing challenges and the impacts of the COVID-19 pandemic have significantly limited their available time to seek out these resources. See other concerns with the structure and accessibility of the website at Compliance Indicator 49.05 above. This study's review of documentary evidence, interviews with DBHDS OPD and OIH staff, and interviews with 11 sample providers demonstrates that DBHDS continues to expand and improve the types of support and coaching it makes available to DBHDS-licensed providers through the DBHDS Offices of Integrated Health and Provider Development upon request and through	

Compliance Indicator	Facts	Analysis	Conclusion
	for training. (Document 271, interviews with the OPD Director)	various meetings and response to individual provider requests. Information about these resources is available to providers through the DBHDS website. Providers interviewed indicated awareness of these resources and some described ways they had utilized them to assist in appropriately addressing specific operational or service delivery challenges.	

V.B. Analysis of 19h Review Period Findings

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

Compliance Indicator	Facts	Analysis	Conclusion
29.02 The Offices of Licensing and Human Rights perform quality assurance functions of the Department by determining the extent to which regulatory requirements are met and taking action to remedy specific problems or concerns that arise.		At the time of the 18th Period review, the study noted that the *DBHDS Quality Management Plan FY2020* stated that the DBHDS Division of Quality Assurance and Government Relations oversees regulatory, quality assurance, and risk management processes. The division is comprised of the Office of Human Rights and the Office of Licensing. In addition, the study documented that the Office of Licensing (OL) is the regulatory authority for the DBHDS licensed service delivery system. Through quality assurance processes including but not limited to initial application reviews, initial site visits, unannounced inspections, review and investigation of serious incidents and complaints, and issuance of licensing reports requiring corrective action plans (CAPs), the OL ensures the mechanisms for the provision of quality service are monitored, enforced, and reported to the DBHDS leadership. For this 19th Period review, as documented with regard to CI 42.01, DBHDS provided a final *Office of Licensing Guidance for a Quality Improvement Program* dated 11/28/2020 to describe how they ensured the final regulations at *12VAC35-105-620* were implemented. However, as described with regard to CI 42.01, 32.03 and 32.04 above, DBHDS did not provide evidence to show that DBHDS-licensed providers, including CSBs, had completed any needed corrective action to remedy specific problems that address quality improvement plan deficiencies related to provider staff training. Due to the significant delay by DBHDS in providing requested documents for review, this study could not complete any independent examination of the implementation of the regulatory requirements and cannot validate whether provider QI programs meet the criteria.	17th Not Met 19th Not Met

Recommendations

1. The DBHDS Office of Provider Development has established an extensive number of core competency-based training requirements for providers. Given the extensive additional workload that these responsibilities have created for providers and recognizing the significant challenges that providers are facing related to staffing shortages and increased turnover, primary attention for the foreseeable future should be directed to enhancing providers' understanding of the requirements and assisting them through training and consultation rather than on adding additional requirements.
2. DMAS should finalize its guidance document that provides detailed instructions for Health Care Compliance Specialists on how to carry out the QMR process consistently across all providers and should evaluate its impact six months after implementation.
3. DMAS should modify the current QMR process to require:
    a. Establishing a specific time interval between QMRs for non-CSB agencies and adjust scheduling of QMRs accordingly to meet the time interval requirements established;
    b. Review of provider policy/procedure statements relevant to provision of core competency-based training consistent with the requirements at 12VAC30-122-18;
    c. Inclusion, if the provider serves an individual assigned to Tier IV, of at least one individual that meets this criterion to assess compliance with the specific requirements set out in 12VAC30-122-180.C that address required advanced core competencies;
    d. Review of the provider's training policy(ies) as a foundation for understanding and evaluating the provider's staff training processes and procedures and determination of compliance with each of the requirements at 12VAC30-122-180;
    e. Review of documentary evidence that verifies that DSPs/Supervisors who have not yet completed training and competency requirements are accompanied and overseen by other quality staff who have passed the core competency requirements; and,
    f. A validation procedure that includes interviews or observation of DSPs/Supervisors to verify that DSPs/Supervisors can demonstrate required competencies.
4. Based on concerns identified from interviews with each of the 11 providers in the sample for this study about the difficulties they had locating specific information on the DBHDS website, DBHDS should conduct an analysis of its website and make modifications to simplify the process for the user to locate specific information, particularly information related to provider operations and compliance with regulatory requirements.
5. DBHDS should consider including review of relevant information identified from analysis of annual licensing inspections along with the QMR review results in the presentations to providers in the Quarterly Provider Roundtable meetings.
6. Given the large number of very small provider organizations providing waiver services, DBHDS Office of Provider Development should consider modifications to the Supervisory training modules that address more specifically the roles and responsibilities of Supervisors who are also providing direct support services in addition to their supervisory roles. If modifications are made, they should not increase the length of time necessary for overall completion of the required training.

Attachment A: Interviews

V.H.1-V.H.2 (**Provider Training Study**)

1. Ann Bevan, DMAS
1. Jason Perkins, DMAS
2. Threnodiez Baugh, DMAS
3. Bill Zieser, Transportation Unit Manager, DMAS
4. Brittany Castro, Health Care Compliance Specialist, DMAS QMR
5. Jean Pearson, Health Care Compliance Specialist, DMAS QMR
6. Eric Williams, Director of Provider Development, DBHDS
7. Jenni Schodt, Settlement Agreement Director, DBHDS
8. Susan Moon, Office of Integrated Health, DBHDS
9. Jae Benz, Director, Office of Licensing, DBHDS
10. Carrie Craddock, Licensing Specialist, DBHDS
11. Ann Mays, Licensing Specialist, DBHDS
12. Sherry Woodard, Licensing Specialist, DBHDS
13. Veronica Davis, Office of Licensing, DBHDS
14. Rhonda Angel, Regional Manager, Office of Licensing, DBHDS
15. Elaine Moser, Regional Manager, Office of Licensing, DBHDS
16. Kesia Gwaltney, Regional Manager, Office of Licensing, DBHDS
17. Angelica Howard, Special Investigations Unit Manager, Office of Licensing, DBHDS
18. Britt Welch, Director, Office of Community Quality Management, DBHDS

Provider Agencies:

19. AEM Love – MaeSunn Moses-Walker, Owner, Operational Director, and Trainer
20. Begonia Home Health – Namina Kamara, Director, and Bukie Olaiya, Operations Assistant
21. Eastern Shore CSB – Kathy O'Keefe, Executive Director and Debra Weatherly, Residential Director
22. Eagles Nest – Ann Massey, Residential Manager
23. Giving Hearts – Allison Joyner, Owner and Kim Dyette, Residential Supervisor
24. Medical Professionals On-Call – Hagar Wiafe, Director and Becky Appiah, Training Coordinator
25. Mount Rogers CSB – Wendy Gullion, Executive Director, Alisha Walker and Ava Mitchell, Program Managers
26. New Beginning, Inc. – Marilyn Newby, Owner, Gloridine Lambert, Owner, Katherine Johnson, Training Coordinator
27. Nirvana Residential Services – Nathan Brown and Stacy Brown, Owners, Operators and Trainers
28. Region Ten CSB – Tara Perreault, Residential Program Manager; Adrienne Poazini, Residential Program Manager; Heather Hines, Senior Director of Adult Developmental Services; JoAnn Murphy, Director of Residential Services; Lisa Bozwell, Residential Program Manager; Lisa Hearl, Training Program Manager; Jennifer Bates, Director of Training; Xavia Jackson, Director of Compliance and IT
29. St. Vincent's Home – Heather Hicks, Program Director and Lauren Shaw, BCBA

Attachment B: Documents Reviewed

V.H.1-V.H.2 (Provider Training Study)

49.01:

1. Virginia Administrative Code-12VAC30-122-180 "Orientation Testing; Professional Competency Requirements; Advanced Competency Requirements
2. DSP Q&C – Protocol – 2020
3. DD2 DSP and Supervisors Competencies Checklist P241a 7.12.21 Final.docx
4. DBHDS Health Competencies Checklist p244a1.19.17_final_rev.pdf (DMAS P244a)
5. VADDA Autism Competencies 9.1.17P201Final_rev.pdf (DMAS #P201)
6. VA DD Behavioral Competencies 9.1.17 P240a final for online.pdf (DMAS P240a)
7. Direct Support Professional Overview 3.9.21.pdf
8. Blank DSP Supervisor Certificate.pdf
9. DSP O&C – Training Resources Announcement – 2021.pdf
10. DSP O&C – Update Announcement – 2020.pdf
11. DSP O&C – Regional Training Announcement – 2020.pdf
12. DSP O&C – Virginia Regulatory Town Hall – DSP Protocol Posting 2020.pdf
13. DSP O&C – Provider Hub Website – Protocol – 2021.pdf
14. DBHDS Announcement "Supplemental DSP Training Updates Effective November 15, 2021"
15. DSP Orientation Test and Answer Sheets Effective 11.15.21
16. Narrative Version – DSP Supplemental Training Choking Risk 9.15.21.docx
17. Narrative Version – DSP Supplemental Training Recognizing Changes in Mental Status 9.15.21.docx
18. Direct Support Professional Training and Competencies Overview 3.5.21
19. 49.02:
20. Virginia Administrative Code-12VAC30-122-180 "Orientation Testing; Professional Competency Requirements; Advanced Competency Requirements
21. New CL.FIS.BI Waiver Regulations Announcement 3-18-2021
22. Commonwealth of Virginia Mail – [EXTERNAL] DD Waiver Regulations – Implementation May 1, 2021
23. DRAFT Change in Mental Status 7.1.21 final.pptx
24. DRAFT Choking Risk 7.1.21 final.pptx
25. List of QMR completed 4th qtr. FY21.docx
26. QMR BI CL FIS Tool Waiver Authority_2021.xlsm
27. QMR Tool Instructions to DBHDS_08.27.21.pdf
28. Change in Mental Status 8-5-21 with stakeholder feedback[V2].pptx
29. Choking Risk 8.17.21 with stakeholder feedback[V2].pptx
30. DSP Orientation Test and Answer Sheets Effective 11.15.21
31. Revised Draft QRT EOY Report 6 20-20 (for comments).pdf
32. List of QMR completed 2nd 3rd and 4th qtr. FY21.docx
33. Nirvana Residential Services 1QMR Ltr.pdf
34. Nirvana Residential Services 2CAP.pdf
35. Nirvana residential Services 3cap app ltr.pdf
36. Begonia Home Health 1QMR Ltr.pdf
37. Begonia Home Health 2CAP.pdf
38. Begonia Home Health 3 cap app lrt.pdf
39. Eastern Short CSP QMR Ltr.pdf
40. ESCSB cap app CL FIS.pdf
41. Eastern Shore CSB 3cap app ltr(1).pdf
42. AEM Love 1QMR Ltr (1). pdf

43. AME Love 2CAP (1).pdf
44. AEM Love 3cap app ltr (1).pdf
45. New Beginnings 1QMR ltr (1).pdf
46. New Beginnings 2CAP.docx
47. New Beginnings 3cap app ltr.pdf
48. Eeagles Nest 1QMR ltr.pdf
49. Eeagles Nest CAP.pdf
50. Eeagles Nest CAP app ltr.pdf
51. Giving Hearts 1QMR ltr.pdf
52. Giving Hearts 2CAP.pdf
53. Giving Hearts 3 cap app ltr.pdf
54. Med Prof On Call 1QMR ltr.pdf
55. Med Prof On Call 2CAP.pdf
56. Med Prof On Call 3cap app ltr.pdf
57. Region Ten CSP 1QMR ltr.pdf
58. Region Ten CSB 2aCAP BI 1-5+CL 1-9+FIS 1-2 4232021rej.xlsx
59. Region Ten CSB 2bCAP GRID FOR FIS 1-2 5-19-21rej.xlsx
60. Region Ten CSB 2cCAP GRID FOR FIS 3-13 _ CL 10-22 5-19-21ref.xlsx
61. Region Ten CSM 3cap reject ltr.pdf
62. Region Ten CSB 4aCAP.xlsx
63. Region Ten CSB 4bCAP.xlsx
64. Region Ten CSB 5cap app ltr.pdf
65. Mt Rogers CSB 1QMR ltr.pdf
66. Mt Rogers CSB 2CAP.pdf
67. Mt Rogers CSB 3cap app ltr.pdf
68. St. Vincent's Home 1QMR Ltr.pdf
69. St Vincent's Home 2CAP.pdf
70. St Vincent's Home 3cap app ltr.pdf
71. Provider Training Study Provider Contact Information_09.13.21.xlsx_19th Review Period.pdf
72. DRAFT Medicaid Memo-DSP Test Update 9.21.2021.pdf
73. DD2 DSP and Supervisors Competencies Checklist P241a 7.12.21 Final.docx
74. 49.03:
75. Virginia Administrative Code-12VAC30-122-180 "Orientation Testing; Professional Competency Requirements; Advanced Competency Requirements
76. DD2 DSP and Supervisors Competencies Checklist P241a 7.12.21 Final.docx
77. DSP Assurance (DMAS P242a) 7.1.21.pdf
78. Supervisor Assurance (DMAS P245a) 7.1.21.pdf
79. QMR Tool Instructions to DBHDS_08.27.21.pdf

49.04:

80. Virginia Administrative Code-12VAC30-122-180
81. Provider Data Summary Report November 2020 final.pdf
82. Provider Data Summary Report May 2021 final (7.22.21).pdf
83. 4th QTR KPA Workgroups Report to the QIC (PCC CII Slides Only).pptx
84. RQC 3rd QTR Report to the QIC 3-22-2021.Final.pdf
85. CRC Activity Log for 2nd, 3rd, and 4th quarter FY21 with highlighting FY21.pdf
86. Commonwealth of Virginia Mail – Targeted Competency Training 52021.pdf
87. Reviewed RQC3 QII SFY2021 – DSP Competency (Region 3).pptx
88. Applicable results from Region III QII (8.6.21).pptx
89. DRAFT Prov Rem Guidance Doc template 2-26-20(1).pdf
90. Quality Review Team (QRT) Year End Report 7/1/2018-6/30/2019.docx

91. Final QRT 2nd Qtr Meeting Notes 5-2020.docx
92. Final QRT 3rd Qtr Meeting Notes new format(1).docx
93. Data Verification MQ_V.H.1_Provider Data Summary rpt Data Source EW [10/19/2020].docx
94. QMR Tool Instructions to DBHDS_08.27.21.pdf
95. Number of Providers and Individuals DSP-Supported 9152021.pdf
96. FY21 QII – PCC KPA Proposed QII slides, pptx
97. Revised RQC3 QII SFY2021 – DSP Competency.pptx
98. SFY2022.Q1.RQC3.QII Report, 2021.pptx
99. REVISED DRAFT – Individuals are supported by trained, competent DSPs (9.23.21).pdf

49.05:

101. January 2021 Newsletter.pdf
102. February 2021 Newsletter.pdf
103. March 2021 Newsletter.pdf
104. April 2021 Newsletter.pdf
105. May 2021 Newsletter.pdf
106. June 2021 Newsletter.pdf
107. July 2021 Newsletter.pdf
108. September 2021 Newsletter.pdf
109. January 2021 Nursing Meeting Agenda. pdf
110. February 2021 Nursing Meeting Agenda. pdf
111. March 2021 Nursing Meeting Agenca.pdf
112. April 2021 Nursing Meeting Agenda. pdf
113. May 2021 Nursing Meeting Agenda.pdf
114. June 2021 Nursing Meeting Agenda.pdf
115. July 2021 Nursing Meeting Agenda.pdf
116. August 2021 Nursing Meeting Agenda.pdf
117. Dental Health Awareness H&S Alert – July 2021.pdf
118. Basic Nutrition H&S Alter – May 2021.pdf
119. Sepsis H&S Alert – Jan 2021.pdf
120. Urinary Tract Infection H&S Alert – Mar 2021.pdf
121. Healthcare Advocacy H&S Alert – April 2021.pdf
122. Psychotropic Medications H&S Alert – Feb 2021.pdf
123. Grief & Loss H&S Alert – Sept 2021.pdf
124. OIH Fall 2021 Training Announcement Flyer(1).pdf
125. OIH Training Records V.H Study QA.08.23.2921.docx
126. DOJ - FY21 Q3 - Crisis - Behavioral Supports Report_4.15.2021 DRAFT.pdf
127. DOJ - FY21 Q1 - Crisis - Behavioral Supports Report 10.15.20 DRAFT.pdf
128. Bi-Annual Report to RMRC Health and Safety Alerts June 2020.pdf
129. Bi-Annual Report to RMRC Health and Safety Alerts December 2020.pdf
130. Bi-Annual Report to RMRC Health and Safety Alerts June 2021.pdf
131. OIH Division of Developmental Services Weekly Report 9.13.21 (copy).docx
132. OIH Technical Assistance Sample 09.21.21.xlsx
133. Practice Guidelines for Behavior Support Plans

49.06:

134. Virginia Administrative Code-12VAC30-122-180 "Orientation Testing; Professional Competency Requirements; Advanced Competency Requirements
135. 4.4.2 VA Transportation Provider Agreement.docx
136. 2020 TMSU Key Activities FINAL with cover.docx
137. 2021 QRT 2 Liquidated Damages and Sanctions Report.xlsx

138. DMAS Fee-For-Service (FFS) Non-Emergency Transportation (NEMT) Driver, Attendant and Vehicle Requirements 03/05/2021
139. Breakdown of Specific Details on Medicaid recoupments for transportation issues 09.24.2021

49.07:

100. January 2021 Newsletter.pdf
101. February 2021 Newsletter.pdf
102. March 2021 Newsletter.pdf
103. April 2021 Newsletter.pdf
104. May 2021 Newsletter.pdf
105. June 2021 Newsletter.pdf
106. July 2021 Newsletter.pdf
107. September 2021 Newsletter.pdf
108. January 2021 Nursing Meeting Agenda. pdf
109. February 2021 Nursing Meeting Agenda. pdf
110. March 2021 Nursing Meeting Agenca.pdf
111. April 2021 Nursing Meeting Agenda. pdf
112. May 2021 Nursing Meeting Agenda.pdf
113. June 2021 Nursing Meeting Agenda.pdf
114. July 2021 Nursing Meeting Agenda.pdf
115. August 2021 Nursing Meeting Agenda.pdf
116. Dental Health Awareness H&S Alert – July 2021.pdf
117. Basic Nutrition H&S Alter – May 2021.pdf
118. Sepsis H&S Alert – Jan 2021.pdf
119. Urinary Tract Infection H&S Alert – Mar 2021.pdf
120. Healthcare Advocacy H&S Alert – April 2021.pdf
121. Psychotropic Medications H&S Alert – Feb 2021.pdf
122. Grief and Loss H&S Alert – Sept 2021.pdf
123. OIH Fall 2021 Training Announcement Flyer(1).pdf
124. OIH Training Records V.H Study QA.08.23.2021.docx
125. OIH Consultation Evidence Q1 FY21 MRC Quarterly Report to Commissioner(1)pdf
126. OIH Consultation MRC Quarterly Report to Commissioner Q2 FY21(1).pdf
127. OIH Technical Assistance Sample 09.21.21.xlsx

49.08:

128. Virginia Administrative Code-12VAC35-105-30
129. Virginia Administrative Code-12VAC35-105-440
130. 4.29.21 OL Annual Checklist Compliance Determination Chart – FY2021.pdf
131. Return-to-field-operations-(march-2021).pdf
132. Memo-to-all-idd-providers-annual-inspections-2-12-21.pdf
133. Provider Training Policies – 9 licensed provider organizations in the sample review (see detailed list at CI 49.12 below)

49.09:

134. Virginia Administrative Code-12VAC35-105-665.D
135. 4.29.21 OL Annual Checklist Compliance Determination Chart – FY2021.pdf
136. DBHDS Health Competencies Checklist p244a1.19.17_final_rev.pdf (DMAS P244a)
137. Return-to-field-operations-(march-2021).pdf
138. Memo-to-all-idd-providers-annual-inspections-2-12-21.pdf
139. Memo to DBHDS Licensed Providers "Individuals with Developmental Disabilities with High-Risk Health Conditions 05.28.2021. pdf

140. Provider Training Policies – 9 licensed provider organizations in the sample review (see detailed list at CI 49.12 below)

49.10:

141. Virginia Administrative Code-12VAC30-122-120.A.20
142. Virginia Administrative Code-18VAC90-21-30 & 40
143. Virginia Administrative Code-12VAC35-105-770
144. Virginia Administrative Code-12VAC35-105-790
145. Virginia Administrative Code-12VAC35-105-450.pdf
146. DD2 DSP and Supervisors Competencies Checklist P241a 7.12.21 Final.docx
147. BON Approved Med Aid Curriculums. Pdf
148. DSP Assurance (DMAS P242a) 7.1.21.pdf
149. 18VAC90-21-40 Post-Course Examination.pdf
150. Supervisor Assurance (DMAS P245a) 7.1.21.pdf
151. QMR Tool Instructions to DBHDS_08.27.21.pdf

49.11:

152. Virginia Administrative Code-12VAC30-122-120.A.21
153. Virginia Administrative Code-12VAC35-105-810
154. Virginia Administrative Code-12VAC35-115-110.C.10
155. DD2 DSP and Supervisors Competencies Checklist P241a 7.12.21 Final.docx
156. 4.29.21 OL Annual Checklist Compliance Determination Chart – FY2021.pdf
157. QMR Tool Instructions to DBHDS_08.27.21.pdf

49.12:

158. Virginia Administrative Code-12VAC35-105-30
159. Virginia Administrative Code-12VAC35-105-450
160. Virginia Administrative Code-12VAC35-105-50, 100, 110, 150
161. DRAFT Provider Remediation Guidance Doc template 2-26-20(1).pdf
162. 4.29.21 OL Annual Checklist Compliance Determination Chart – FY2021.pdf
163. Return-to-field-operations-(march-2021).pdf
164. Memo-to-all-idd-providers-annual-inspections-2-12-21.pdf
165. Description of Regulatory Enforcement Action Options 12VAC35-105-50, 100,110,150.docx

49.13:

166. Statewide 2021 SC CM PRT Agenda 4-2021 talking notes final final.pdf
167. Statewide 2021 SC CM PRT agenda notes 2-5-21 final.pdf
168. Commonwealth of Virginia Mail – [EXTERNAL] Provider Roundtable Materials from February 5, 2021.pdf
169. Statewide PRT SC Agenda 7-2021 final (5).pdf
170. Statewide PRT SC power point 2-2021 final [2.5.21] (slides 22, 23, 24, 25).pdf
171. Statewide PRT SC power point 7-2021 [Slides 36 and 37].pptx
172. Statewide PRT SC power point 4-2021 [Slides 34, 35, 36].pptx
173. Approved HCBS Waiver Application – "Building Independence Waiver"
174. Approved HCBS Waiver Application – "Family and Individuals Supports Waiver"
175. Approved HCBS Waiver Application – "Community Living Waiver"
176. Process Description for PRT Agenda and QMR Meetings provided by Eric Williams

50.01:

177. Virginia Administrative Code-12VAC30-122-180
178. DSP Orientation Test and Answer Sheets Effective 11.15.21

179. Commonwealth of Virginia Mail – [EXTERNAL] Centralized Training for Providers.pdf
180. Commonwealth of Virginia Mail – [EXTERNAL] Updated DSP Supervisory Training Available on July 1, 2020.pdf
181. DSP Supervisory Training Module 1 online training (COVLC)
182. DSP Supervisory Training Module 2 online training (COVLC)
183. DSP Supervisory Training Module 3 online training (COVLC)
184. Blank DSP Supervisor Certificate.pdf
185. Supervisor Assurance (DMAS P245a) 7.1.21.pdf
186. January 2021 Nursing Meeting Agenda.pdf
187. February 2021 Nursing Meeting Agenda (2).pdf
188. March 2021 Nursing Meeting Agenda (2).pdf
189. April 2021 Nursing Meeting Agenda (1).pdf
190. Provider Data Summary Report May 2021 final (7.22.21).pdf

50.02:

191. Virginia Administrative Code-12VAC30-122-180
192. DSP Orientation Test and Answer Sheets Effective 11.15.21
193. Commonwealth of Virginia Mail – [EXTERNAL] Centralized Training for Providers.pdf
194. Commonwealth of Virginia Mail – [EXTERNAL] Updated DSP Supervisory Training Available on July 1, 2020.pdf
195. DSP Supervisory Training Module 1 online training (COVLC)
196. DSP Supervisory Training Module 2 online training (COVLC)
197. DSP Supervisory Training Module 3 online training (COVLC)
198. Supervisor Assurance (DMAS P245a) 7.1.21.pdf
199. Provider Data Summary Report May 2021 Final 8-4-21 Final.pdf

50.03:

200. Commonwealth of Virginia Mail - [EXTERNAL] Provider Roundtable invitation for 2_5_21 12pm to 2pm.pdf
201. SC Regional Meetings Feb 2021 Region V FINAL.pdf
202. April 29th Support Coordinator meeting invite Region 5.pdf
203. Region I SC Supervisor mtg Jan.pdf
204. Region I SC Supervisor mtg April.pdf
205. Region I SC Supervisor meeting July.pdf
206. Region 2 R2SC Feb 2021.pdf
207. Region II R2SC April 2021.pdf
208. Region III SC Supervisor Mtg Jan.pdf
209. Region III SC Supervisor mtg April.pdf
210. Region III SC Supervisor Mtg July.pdf
211. Region IV SC Meeting printeventFeb.pdf
212. Region IV SC Meeting printeventApril.pdf
213. PRT-SC Meeting Q&A April 2021 7.23.21 final (2).pdf
214. Region IV SC Meeting printeventJuly.pdf
215. Region V July 29th, 2021 Regional Support Coordinator meeting.pdf
216. Statewide PRT SC Agenda 7-2021 final Region V sc.doc
217. Commonwealth of Virginia Mail - [EXTERNAL] (Subject Correction) Provider Roundtable invitation for 7_27_21 - 12_30pm to 2_30pm.pdf
218. Commonwealth of Virginia Mail - [EXTERNAL] Provider Roundtable invitation for 4_27_21 - 1_30pm to 3_30pm.pdf
219. Commonwealth of Virginia Mail - [EXTERNAL] Provider Roundtable April Q&A.pdf
220. Statewide SC CM PRT agenda speaker notes 2-2021JULIE NOTES 5.doc

221. Statewide PRT SC power point 2-2021 final [2.5.21] (1).pdf
222. Statewide 2021 SC CM PRT agenda 4-2021 talking notes final for SC mtg Region V.doc
223. Statewide PRT SC power point 4-2021 Region V [Autosaved].pptx
224. Statewide PRT SC power point 7-2021 [Autosaved].pptx
225. January 2021 Nursing Meeting Agenda. pdf
226. February 2021 Nursing Meeting Agenda. pdf
227. March 2021 Nursing Meeting Agenda.pdf
228. April 2021 Nursing Meeting Agenda. pdf
229. May 2021 Nursing Meeting Agenda.pdf
230. June 2021 Nursing Meeting Agenda.pdf
231. July 2021 Nursing Meeting Agenda.pdf
232. August 2021 Nursing Meeting Agenda.pdf
233. OPD Support and Coaching Description 9.23.21.pdf
234. DBHDS Centralized Training for Providers Website

APPENDIX H

QUALITY and RISK MANAGEMENT SYSTEM

By

Rebecca Wright MSW, LICSW

Consortium on Innovative Practices

DRAFT

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

Quality and Risk Management System

By

Rebecca Wright, MSW, LICSW
Consortium on Innovative Practices

November 13, 2021

Quality and Risk Management System 19th Review Period Study

The Settlement Agreement in U.S. v. Commonwealth of Virginia requires the Commonwealth to ensure that all services for individuals receiving services under this Agreement are of good quality, meet individual's 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. For this 19th Period review, the related provisions are as follows:

Section V.C.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.

Section V.D.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.

Section V.D.2 a-d: 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.

Section V.D.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: Safety and freedom from harm (e.g., neglect and abuse, injuries, use of seclusion or restraints, deaths, effectiveness of corrective actions, licensing violations); 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); 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);Stability (e.g., maintenance of chosen providers, work/other day program stability); 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); Community inclusion (e.g., community activities, integrated work opportunities, integrated living options, educational opportunities, relationships with non-paid individuals); 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 Provider capacity (e.g., caseloads, training, staff turnover, provider competency).

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

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

Section V.D.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.

Section V.E.I: 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 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.

Section V.E.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.

Section V.E.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.

The Parties (i.e., the Commonwealth of Virginia and the U.S. represented by DOJ) jointly submitted to the Federal Court a complete set of compliance indicators for all provisions with which Virginia had not yet been found in sustained compliance. The agreed upon compliance indicators were formally submitted on Tuesday, January 14, 2020. The Independent Reviewer's previous report with regard to these provisions, (i.e., his 17th Report to the Court, dated December 15, 2020), found the Commonwealth had met the requirements for compliance for one of the 55 provisions (V.H.2.) overall, and had met requirements for some of the associated Compliance Indicators (CIs) for the other 54.

For this 19th Period review, the Independent Reviewer again prioritized the study of the provisions set out above.

Study Purpose and Methodology:
In April 2019, the Court directed the Commonwealth to develop a library (i.e., the Library Website) of documents that would show the Court the source of Virginia's authority (i.e., its organizational structure, policies, action plans, implementation protocols, instructions/guidelines, applicable compliance monitoring forms, sources of and actual data, quarterly reports, etc.) needed to demonstrate compliance. Accordingly, this study attempted to identify a minimum set of finalized policies, procedures, instructions, protocols and/or tools that will be needed for the Independent Reviewer to formulate his determinations whether the CIs have been met and the Provisions achieved, and to determine if DBHDS had them in place. In addition, the Independent Reviewer asked the consultants to determine the status of Commonwealth's determinations that its data sources provide reliable and valid data, as well as the documents and the method of analysis the Commonwealth is using, or plans to use, to determine whether it is maintaining "sufficient records to document that the requirements of each provision are being properly implemented," as measured by the relevant compliance indicators. "Sufficient Records" also encompasses required reporting commitments.

The study methodology included document review, DBHDS staff interviews, and review and analysis of data from sources that DBHDS determined to be valid and reliable as well as other available data. A full list of documents and data reviewed may be found in Attachment A. A full list of individuals interviewed is included in Attachment B. The purpose of the study and the related components of the study methodology were shared with DBHDS staff at the end of July 2021. DBHDS was also asked to provide all necessary documents and to suggest interviews that provides information that demonstrates proper implementation of the Provision and its associated CIs. There was a significant, and unfortunate, delay in DBHDS's production of requested documents and in the arrangement of staff interviews. As a result, some aspects of the proposed study methodology (e.g., interviews with a sample of providers, CSBs and Regional Council members) could not be completed as planned. In addition, many documents were not provided in time for the consultant to complete any independent verification of their content.

Summary of Findings:
According to the *DBHDS Quality Management Plan FY2020,* DBHDS is committed to Continuous Quality Improvement (CQI), which the *Plan* describes "an ongoing process of data collection and analysis for the purposes of improving programs, services, and processes." The *DBHDS Quality Management Plan* further describes quality improvement as a "systematic approach aimed toward achieving higher levels of performance and outcomes through establishing high quality benchmarks, utilizing data to monitor trends and outcomes, and resolving identified problems and barriers to goal attainment, which occurs in a continuous feedback loop to inform the system of care," and as a "data driven process" that involves analysis of data and performance trends that is used to determine quality improvement priorities.

As described at the time of the two previous studies, in the fall of 2019 and 2020, the functionality of the Commonwealth's framework is severely hampered by the lack of valid and reliable data across much of the system. These previous studies have found that issues of data validity and reliability negatively impacted the ability of DBHDS staff to complete meaningful analyses of the various data collected to effectively identify and implement needed improvements. While DBHDS collected considerable data from various sources, significant issues with the reliability and validity of the data existed throughout the system. For this review, this remained an overarching theme that negatively impacts the ability of DBHDS to fully implement its commitment to Continuous Quality Improvement, as described in the *Quality Management Plan.*

In 2019, at the time of the 15th Period review, the study documented that the Office of Data Quality and Visualization (Office of DQV) had implemented a multi-phase initiative that delved deeply into issues of data reliability and validity across multiple systems. In summary, the results documented data quality issues within each of the commonly-used source systems, which included, but were not limited to, a lack of

advanced controls, confusing user interfaces, limited key documentation, duplication and redundancies, requirements for manual linking across systems and a need to improve/create/maintain documentation of all the processes required to produce the data (i.e., data provenance.). All of these factors contributed to concerns for data reliability and negatively impacted the quality and trust of data in the Data Warehouse (DW) processes used to develop reports. In recognition of the inherent flaws in the source systems, DBHDS staff had been endeavoring to develop various "work-arounds" to enhance the reliability of the data. However, many of those work-around processes were not documented and therefore subject to interpretation and human error. Without that documented data provenance, DBHDS was not yet able to demonstrate that data were reliable.

For the17th Period review, the Independent Reviewer requested that DBHDS provide documentation to show that the Office of DQV completed the required annual reliability and validity assessments of data sources and determined that the data sources provided reliable and valid data for compliance reporting. The DBHDS response indicated that the annual reliability and validity assessments of data sources would not take place until June 2021. Other documentation submitted at that time (i.e., *Validity and Reliability: Assessment of Key Performance Area Performance Indicators*, dated 1/4/21 and *Validity and Reliability Assessment of Key Performance Area Performance Indicators KPA Teams Meeting*, dated 1/28/21) indicated that data source systems continued to present barriers to the collection of reliable and valid data and acknowledged that performance measures might draw data from a source system that was known to have weak validity or reliability. The documents concluded it would become essential to prioritize recommendations from the *Data Quality Monitoring Plan* and align these results with IT strategic plans and, further, noted that until that occurred, source systems might continue to have limitations that affect their ability to produce consistent, reliable data . This is a critical finding because, pursuant to CI 36.06, data sources cannot be used for compliance reporting until they have been found to be valid and reliable..

For this 19th Period Review, the Office of DQV acknowledged that the recommendations from the original version of the *DBHDS Data Quality Monitoring Plan* had not yet been addressed in a comprehensive manner, but that DBHDS had issued several additional documents as updates. These included the *Data Quality Monitoring Plan: Annual Update Process,* dated April 2021; the *Data Quality Monitoring Plan Source System Annual Update*, dated June 2021; and, the *Data Quality Monitoring Plan: Reassessment with Actionable Recommendations*, also dated June 2021. Based on the documentation provided for this review, as well as interviews with key staff, DBHDS had not yet fully addressed the findings and recommendations of these DQMP self-assessments. While *Data Quality Monitoring Plan Source System Annual Update,* dated June 2021, outlined some steps taken to improve data quality in eight of the previously-studied source systems, DBHDS did not assert that it had completed the remediation of the substantive reliability and validity problems that it had identified in its previous assessments, completed assessments that verified that the data provided were now reliable and valid, or made the required determinations that any of its source systems produced valid and reliable data for compliance reporting. Of note, due to the significant delay by DBHDS in providing these documents for review, this study could not complete an independent verification of the assertions or processes contained in the documents.

Overall, because CI 36.01 requires that data sources will not be used for compliance reporting until they have been found to provide valid and reliable data and that DBHDS conduct this evaluation at least annually, the facts in the preceding paragraphs permeate the findings for many of the CIs reviewed for this study as well as the Independent Reviewer's other 19th Review Period studies.

V.C.4: This review examined the progress DBHDS had made in offering training and guidance to providers on proactively identifying risks of harm, conducting root cause analyses and developing and monitoring corrective actions. It was positive that DBHDS staff continued to expand upon the availability and update the training and guidance to providers on these topics. However, CI 32.07 requires that DBHDS use data and information from risk management activities, including mortality reviews to identify

topics for future content; make determinations as to when existing content needs to be revised; and identify providers that are in need of additional technical assistance or other corrective action. As described above, DBHDS has not found the data sources to be valid and reliable, so they cannot be used for compliance reporting. In addition, DBHDS did not provide sufficient evidence to show that it had required providers determined to be non-compliant with risk management requirements to complete the requisite training.

V.D.1: This review examined the extent to which DBHDS operated its HCBS Waivers in accordance with the CMS approved waiver quality improvement plan, including the review of waiver performance measures in six domains (i.e., the waiver Assurances.). The study found that the CMS approved waiver quality improvement plan included all of the required criteria and that DMAS and DBHDS had developed Waiver performance measures that were posted on the CMS and DBHDS websites and that the Quality Review Team (QRT) reviewed quarterly. However, the lack of valid and reliable data hampered the ability of the QRT to make accurate analyses, and the QRT minutes continued to show the QRT often failed to focus on systemic remediation. The QRT issued an End of Year report, but it was not timely for this review period.

V.D.2 a-d: This review examined the progress DBHDS had made toward the ability to collect and analyze reliable and valid data with regard to availability, accessibility and quality of services to people in the target population and the progress DBHDS had made in the development and implementation of performance measures and associated surveillance data. As described with regard to the summary above, DBHDS issued updates to the Data Quality Management Plan, but had not completed an annual (i.e., within 365 days of the previous) review of the data source systems. In addition, the Office of DQV had not consistently completed a review of the data collection methodologies DBHDS staff used to collect Performance Measure Indicator (PMI) data. Many PMIs had not been reviewed in the past 12 months or following modifications to the data collection methodology and some had not yet been reviewed. Overall, the lack of valid and reliable data negatively impacted the Commonwealth's ability to achieve some of this provision's CIs.

V.D.3: This review examined the progress DBHDS had made toward the development of specific measures in the eight domains specified in Section V.D.3. (i.e., safety and freedom from harm; physical, mental, and behavioral health and wellbeing; avoiding crises; stability; choice and self- determination; community inclusion; access to services; and, provider capacity), and for the key performance areas (KPAs) and related data collection methodologies and sources. DBHDS had established workgroups and committees and designated each with specific responsibilities for developing and monitoring measures and surveillance data in each of the eight domains. However, the implementation of the monitoring and measuring responsibilities continued to be negatively impacted by the lack of valid and reliable data.

V.D.4: This review examined the progress DBHDS had made in the areas of collecting and analyzing data from a set of prescribed sources. The single compliance indicator for this provision requires the Commonwealth to collect and analyze data from 13 source systems, at a minimum. At the time of the 19th Period review, DBHDS continued to collect data from all of the designated sources . While the *Data Quality Monitoring Plan Source System Annual Update,* dated June 2021, outlined some steps taken to improve data quality in eight of the previously-studied source systems, DBHDS did not assert that any of the source systems produced valid and reliable data. The Data Quality Monitoring Plan Source System Annual Update outlined some steps taken to improve data quality in eight of the previously-studied source systems, but did not assert that any of the source systems produced valid and reliable data. Due to the significant delay by DBHDS in providing documents for review, this study could not complete any independent examination of the implementation of the improvements listed therein and cannot validate the assertions or the extent to which any of them might have sufficiently ameliorated the previously-identified concerns/deficiencies.

V.D.5: This review examined the progress DBHDS had made toward the implementation of Regional Quality Councils (RQCs). Each of the five regions within the Commonwealth had convened regular quarterly meetings of their appointed RQC, achieving a quorum each time, and served as a subcommittee to the DBHDS Quality Improvement Committee (QIC.) The RQC minutes for the last two quarters of the State Fiscal Year (SFY) showed significant improvement over the first two quarters, in terms of specific data provided for review and the relevance to the roles and responsibilities of the RQCs as defined in their charters. All five RQCs had also recommended and implemented a quality improvement initiative (QII) for this review period that also reflected significant improvement in their use of data. However, while the RQCs had improved their processes for reviewing and evaluating data, trends, and monitoring efforts and using those effort to recommend quality improvement initiatives to the QIC annually, their work was compromised by a lack of measurable outcomes and the overall lack of valid and reliable data.

V.D.6: This review examined the progress DBHDS had made toward public reporting with regard to the availability and quality of supports and services. For this period, DBHDS was not compliant with any of the CIs. This was primarily due to a failure to provide required annual updates to the specified documents. Overall, DBHDS should examine the timelines for report production to ensure an update at least annually, as well as the adherence to the established protocols for an annual audit.

V.E.1: This review examined the progress DBHDS had made with regard to requirements for all providers to have quality improvement programs. DBHDS has published written guidance for providers on developing and implementing the requirements of 12 VAC 35-105-620 consistent with the regulation, but DBHDS did not provide any policy, procedure or operational protocol to show how DBHDS staff would determine whether updates and/or revisions to this guidance were necessary. DBHDS did not provide evidence to show that DBHDS-licensed providers, including CSBs, had completed any needed corrective action to address quality improvement plan deficiencies related to provider staff training, or current documentation to show the Training Center had in place the required procedures, protocols and/or processes to implement a quality improvement program. In addition, the related performance measure methodologies did not clearly show they would be valid for this CI.

V.E.2: This review examined the progress DBHDS had made with regard to requirements for provider reporting of key indicators selected from the relevant domains in Section V.D.3. The Commonwealth has established performance measures, reviewed quarterly by DMAS and DBHDS, as required and approved by CMS in the requisite areas. However, this provision also requires that the sources of data for reporting shall be such providers' risk management/critical incident reporting and their QI programs, but DBHDS only collects data from the providers' critical incident reporting. In addition, DBHDS did not provide documentation to show that the Office of DQV completed sufficient needed assistance with analysis of all of the provider reporting measures, as required by CI 43.03 to ensure that the data sources are valid, identify what the potential threats to validity are, and ensure that the provider reporting measures are well-defined and measure what they purport to measure. In addition, based on the findings for CI 36.01 and CI 38.01, the Office of DQV had not yet determined that the applicable data source systems produced valid and reliable data, so the data cannot be used to support compliance findings.

V.E.3: This review examined the progress DBHDS had made with regard to the Commonwealth's processes to assess the adequacy of providers' quality improvement strategies and to provide technical assistance and other oversight to providers whose quality improvement strategies the Commonwealth determines to be inadequate. However, DBHDS did not provide any documentation to evidence compliance. In addition, compliance with these indicators is predicated on the availability of reliable and valid data from the QSRs. As noted above, DBHDS did not provide a response to the Independent Reviewer's request for evidence to show that the Office of DQV had assessed the QSR data collection methodologies and determined the reliability and validity of the data those methodologies produced.

Therefore, this study could also not confirm that the Commonwealth complied with CI 44.01 and CI 44.02.

Conclusion:
The tables below illustrate the current compliance status for each Compliance Indicator.
Note: Since the DBHDS Office of Data Quality and Visualization assessment has not found that data sources provide reliable and valid data for compliance reporting, "Met" determinations are not yet final, but for illustrative purposed only.

V.C.4 Compliance Indicators	Status
32.01: DBHDS will make training and topical resources available to providers on each of the following topics with an application to disability services, or at minimum to human services: a. proactively identifying and addressing risks of harm b. conducting root cause analysis c. developing and monitoring corrective actions.	Met
32.02: Training(s) or educational resources in each topical area identified in Indicator 1 will be made available to providers through the DBHDS website, or other on-line systems.	Met
32.03: Providers that have been determined to be non-compliant with risk management requirements (as outlined in V.C.1, indicator #4) for reasons that are related to a lack of knowledge, will be required to demonstrate that they complete training offered by the Commonwealth, or other training determined by the Commonwealth to be acceptable, as part of their corrective action plan.	Not Met
32.04: Providers that have been determined to be non-compliant with requirements about training and expertise for staff responsible for the risk management function (as outlined in V.C.1, indicator #1.a) and providers that have been determined to be non-compliant with requirements about conducting root cause analyses as required by 12 VAC 35-105-160(E) will be required to demonstrate that they complete training offered by the Commonwealth, or other training determined by the Commonwealth to be acceptable, as part of their corrective action plan process.	Not Met
32.05: DBHDS offers written guidance to providers (including residential, day/employment, and case management) on how to proactively identify and address risks of harm. This content will include: a. Guidance on conducting individual-level risk screening b. Either a tool for risk screening selected by DBHDS or example resources for consideration by providers to use when conducting risk screening c. Guidance on how to incorporate identified risks for individual service recipients into service planning and how to adequately address the risks.	Met
32.06: DBHDS publishes detailed guidance, with input from relevant professionals, about risks common to people with developmental disabilities, which include considerations for how to appropriately and adequately monitor, assess, and address each risk. DBHDS will review its content annually and revise as necessary to ensure current guidance is sufficient and is included in each alert.	Met
32.07: DBHDS will use data and information from risk management activities, including mortality reviews to identify topics for future content; make determinations as to when existing content needs to be revised; and identify providers that are in need of additional technical assistance or other corrective action. Content will be posted on the DBHDS website and the DBHDS provider listserv. Guidance will be disseminated widely to providers of services in both licensed and unlicensed settings, and to family members and guardians.	Not Met
32.08: DBHDS offers written guidance to providers on conducting root cause analysis, and assesses that providers adequately (in accordance with DBHDS's own guidance) identify cases for and conduct root cause analysis.	Met

V.C.4 Compliance Indicators	Status
32.09: DBHDS offers written guidance to providers, including example scenarios, on developing, implementing, and monitoring corrective actions they identify as necessary, as well as identified solutions to mitigate the re-occurrence of serious incidents. This guidance will instruct providers to document their plans for corrective actions resulting from regulatory citations, root cause analyses, or other risk management or quality improvement activities; as well as their actions taken and any related decisions to deviate from planned actions.	Met

V.D.1. Compliance Indicators	Status
35.01: The Commonwealth implements the Quality Improvement Plan approved by CMS in the operation of its HCBS Waivers.	Not Met
35.02: The CMS-approved Quality Improvement Plan in the DD HCBS waivers outlines: a. Inclusion of the evidence-based discovery activities that will be conducted for each of the six major waiver assurances. b. The remediation activities followed to correct individual problems identified in the implementation of each of the assurances. c. Identification of the Department and Division responsible for overall management of the respective QM function(s). DMAS, as the Single State Medicaid Agency, retains overall authority for the operation of the DD HCBS waivers in their entirety. d. Processes to oversee and monitor all components related to the QM Strategy. e. Identification of performance measures that will be assessed. f. Processes to review performance trends, patterns, and outcomes to establish quality improvement priorities. g. Processes to recommend changes to policies, procedures and practices, waivers, and regulation as informed through ongoing review of data. h. Processes to ensure remediation activities are completed and to evaluate their effectiveness. i. Processes to report progress and recommendations to the QIC.	Met
35.03 The Commonwealth has established performance measures, reviewed quarterly by DMAS and DBHDS, as required and approved by CMS in the areas of: a. health and safety and participant safeguards, b. assessment of level of care, c. development and monitoring of individual service plans, including choice of services and of providers, d. assurance of qualified providers, e. whether waiver enrolled individuals' identified needs are met as determined by DMAS QMR, f. identification, response to incidents, and verification of required corrective action in response to substantiated cases of abuse/neglect/exploitation (prevention is contained in corrective action plans).	Not Met
35.04: The performance measures are found in the published DD HCBS waivers and found at cms.gov and are posted on the DBHDS website.	Met
35.05: Quarterly data is collected on each of the above measures and reviewed by the DMAS-DBHDS Quality Review Team. Remediation plans are written and remediation actions are implemented as necessary for those measures that fall below the CMS-established 86% standard. DBHDS will provide a written justification for each instance where it does not develop a remediation plan for a measure falling below 86% compliance. Quality Improvement remediation plans will focus on systemic factors where present and will include the specific strategy to be employed and defined measures that will be used to monitor performance. Remediation plans are monitored at least every 6 months. If such remediation actions do not have the intended effect, a revised strategy is implemented and monitored	Not Met

V.D.1. Compliance Indicators	Status
35.06: DMAS provides administrative oversight for the DD Waivers in compliance with its CMS-approved waiver plans, coordinates reporting to CMS, and conducts financial auditing consistent with the methods, scope and frequency of audits approved by CMS.	Not Met
35.07: The DMAS-DBHDS Quality Review Team will provide an annual report on the status of the performance measures included in the DD HCBS Waivers Quality improvement Strategy with recommendations to the DBHDS Quality Improvement Committee. The report will be available on the DBHDS website for CSBs' Quality Improvement committees to review. Documentation of these reviews and resultant CSB-specific quality improvement activities will be reported to DBHDS. The above measures are reviewed at local level including by Community Service Boards (CSB) at least annually.	Not Met
35.08: DMAS provides administrative oversight for the DD Waivers in compliance with its CMS-approved waiver plans, coordinates reporting to CMS, and conducts financial auditing consistent with the methods, scope and frequency of audits approved by CMS.	Not Met

V.D.2 Compliance Indicators	Status
36.01: DBHDS develops a Data Quality Monitoring Plan to ensure that it is collecting and analyzing consistent reliable data. Under the Data Quality Monitoring Plan, DBHDS assesses data quality, including the validity and reliability of data and makes recommendations to the Commissioner on how data quality issues may be remediated. Data sources will not be used for compliance reporting until they have been found to be valid and reliable. This evaluation occurs at least annually and includes a review of, at minimum, data validation processes, data origination, and data uniqueness.	Not Met
36.02: DBHDS analyzes the data collected under V.D.3.a-h to identify trends, patterns, and strengths at the individual, service delivery, and system level in accordance with its Quality Improvement Plan. The data is used to identify opportunities for improvement, track the efficacy of interventions, and enhance outreach and information.	Met*
36.03 At least annually, DBHDS reviews data from the Quality Service Reviews and National Core Indicators related to the quality of services and individual level outcomes to identify potential service gaps or issues with the accessibility of services. Strategic improvement recommendations are identified by the Quality Improvement Committee (QIC) and implemented as approved by the DBHDS Commissioner.	Not Met
36.04: DBHDS quality committees and workgroups, including Mortality Review Committee, Risk Management Review Committee, Case Management Steering Committee, and Key Performance Area (KPA) workgroups, establish goals and monitor progress towards achievement through the creation of specific KPA Performance Measure Indicators (PMI). These PMIs are organized according to the domains, as outlined in the Settlement Agreement in V.D.3.a-h. PMIs are also categorized as either outcomes or outputs: a. Outcome PMIs focus on what individuals achieve as a result of services and supports they receive (e.g., they are free from restraint, they are free from abuse, and they have jobs). b. Output PMIs focus on what a system provides or the products (e.g., ISPs that meet certain requirements, annual medical exams, timely and complete investigations of allegations of abuse).	Not Met

V.D.2 Compliance Indicators	Status
36.05: Each KPA PMI contains the following: a. Baseline or benchmark data as available. b. The target that represents where the results should fall at or above. c. The date by which the target will be met. d. Definition of terms included in the PMI and a description of the population. e. Data sources (the origins for both the numerator and the denominator) f. Calculation (clear formulas for calculating the PMI, utilizing a numerator and denominator). g. Methodology for collecting reliable data (a complete and thorough description of the specific steps used to supply the numerator and denominator for calculation). h. The subject matter expert (SME) assigned to report and enter data for each PMI. i. A Yes/No indicator to show whether the PMI can provide regional breakdowns.	Not Met
36.06: DBHDS in accordance with the Quality Management Plan utilizes a system for tracking PMIs and the efficacy of preventative, corrective, and improvement measures, and develops and implements preventative, corrective, and improvement measures where PMIs indicate health and safety concerns. DBHDS uses this information with its QIC or other similar interdisciplinary committee to identify areas of needed improvement at a systemic level and makes and implements recommendations to address them.	Not Met
36.07: DBHDS demonstrates annually at least 3 ways in which it has utilized data collection and analysis to enhance outreach, education, or training.	Met*
36.08: DBHDS collects and analyzes data (at minimum a statistically valid sample) at least annually regarding the management of needs of individuals with identified complex behavioral, health and adaptive support needs to monitor the adequacy of management and supports provided. DBHDS develops corrective action(s) based on its analysis, tracks the efficacy of that action, and revises as necessary to ensure that the action addresses the deficiency.	Not Met

V.D.3 Compliance Indicators	Status
37.01: DBHDS has established three Key Performance Areas (KPAs) that address the eight domains listed in V.D.3.a-h. DBHDS quality committees and workgroups, including Mortality Review Committee, Risk Management Review Committee, Case Management Steering Committee and KPA workgroups, establish performance measure indicators (PMIs) that are in alignment with the eight domains that are reviewed by the DBHDS Quality Improvement Committee (QIC). The components of each PMI are set out in indicator #5 of V.D.2. The DBHDS quality committees and workgroups monitor progress towards achievement of PMI targets to assess whether the needs of individuals enrolled in a waiver are met, whether individuals have choice in all aspects of their selection of their services and supports, and whether there are effective processes in place to monitor individuals' health and safety. DBHDS uses these PMIs to recommend and prioritize quality improvement initiatives to address identified issues	Met*
37.02: The assigned committees or workgroups report to the QIC on identified PMIs, outcomes, and quality initiatives. PMIs are reviewed at least annually consistent with the processes outlined in the compliance indicators for V.D.2. Based on the review and analysis of the data, PMIs may be added, deleted, and/or revised in keeping with continuous quality improvement practices.	Not Met

V.D.3 Compliance Indicators	Status
37.03 The KPA workgroups and assigned domains (V.D.3.a-h) are: A. Health, Safety and Well Being KPA workgroup encompasses the domains of: a) Safety and Freedom from Harm b) Physical, Mental, and Behavioral Health and Well being c) Avoiding Crises B. Community Integration and Inclusion KPA workgroup encompasses the domains of: a) Community Inclusion b) Choice and Self-Determination c) Stability C. Provider Competency and Capacity KPA workgroup encompasses the domains of: a) Provider Capacity b) Access to Services.	Met
37.04: The DBHDS Quality Management Plan details the quality committees, workgroups, procedures and processes for ensuring that the committees and/or workgroups establish PMIs and quality improvement initiatives in the KPAs on a continuous and sustainable basis.	Met
37.05: Each KPA workgroup will: a) Establish at least one PMI for each assigned domain b) Consider a variety of data sources for collecting data and identify the data sources to be used c) Include baseline data, if available and applicable, when establishing performance measures d) Define measures and the methodology for collecting data e) Establish a target and timeline for achievement f) Measure performance across each domain g) Analyze data and monitor for trends h) recommend quality improvement initiatives i) Report to DBHDS QIC for oversight and system-level monitoring	Not Met
37.06: DBHDS collects and analyzes data from each domain listed in V.D.3.a-h. Within each domain, DBHDS collects data regarding multiple areas. Surveillance data is collected from a variety of data sources as described in the Commonwealth's indicators for V.D.3.a-h. This data may be used for ongoing, systemic collection, analysis, interpretation, and dissemination and also serves as a source for establishing PMIs and/or quality improvement initiatives.	Not Met
37.07: The Office of Data Quality and Visualization will assess data quality and inform the committee and workgroups regarding the validity and reliability of the data sources used in accordance with V.D.2 indicators 1 and 5.	Not Met
37.08: The Quality Management Annual Report will describe the accomplishments and barriers for each KPA.	Met
37.09: The Health, Safety and Well Being KPA workgroup will finalize surveillance data to be collected for "safety and freedom from harm," at minimum including: a. Neglect and abuse b. Injuries c. Use of seclusion or restraints d. Effectiveness of corrective action e. Licensing violations f. Deaths	Met
37.10: The Health, Safety and Well Being KPA workgroup will develop, initiate, and monitor performance measures with a set target. Measures may be selected from, but not limited to, any of the following data sets: Abuse, neglect and exploitation; Serious incidents and injuries (SIR); Seclusion or restraint; Incident Management; National Core Indicators – (i.e., Health, Welfare and Rights); DMAS Quality Management Reviews (QMRs)	Met*
37.11: The Health, Safety and Well Being KPA workgroup will finalize surveillance data to be collected for "Physical, mental, and behavioral health and well-being."	Met
37.12: The Health, Safety and Well Being KPA workgroup will develop, initiate, and monitor performance measures with a set target. Measures may be selected from, but not limited to, any of the following data sets: SIR; Enhanced Case Management	Met*

V.D.3 Compliance Indicators	Status
(ECM); National Core Indicators - (i.e., Health, Welfare and Rights); Individual and Provider Quality Service Reviews (QSRs); QMRs	
37:13: The Health, Safety and Well Being KPA workgroup will finalize surveillance data to be collected for "avoiding crises," at minimum including: a. Number of people using crisis services b. Age and gender of people using crisis services c. Known admissions to emergency rooms or hospitals d. Admissions to Training Centers or other congregate settings e. Contact with criminal justice system during crisis	Met
37.14: The Health, Safety and Well Being KPA workgroup will develop, initiate, and monitor performance measures with a set target. Measures may be selected from, but not limited to, any of the following data sets: Crisis Data; QMRs; QSRs; Waiver Management System (WaMS); CHRIS	Met*
37.15: The Community Inclusion/Integrated Settings KPA workgroup will finalize surveillance data to be collected for "stability," at minimum including data related to living arrangement, providers, and participation in chosen work or day programs.	Met
37.16: The Community Inclusion/Integrated Settings KPA workgroup will develop, initiate, and monitor performance measures with a set target. Measures may be selected from, but not limited to, any of the following data sets: Employment; Housing; NCI – (i.e., Individual Outcomes); QSRs; WaMS	Met*
37.17: The Community Inclusion/Integrated Settings KPA workgroup will finalize surveillance data to be collected for "Choice and self-determination."	Met
37.18: The Community Inclusion/Integrated Settings KPA workgroup will develop, initiate, and monitor performance measures with a set target. Measures may be selected from, but not limited to, any of the following data sets: Employment; Community Engagement/Inclusion; QSRs; NCI – (i.e., Individual Outcomes); WaMS	Met*
37.19: The Community Inclusion/Integrated Settings KPA workgroup will finalize surveillance data to be collected for "community inclusion," at minimum including data related to participation in groups and community activities, such as shopping, entertainment, going out to eat, or religious activity.	Met
37.20: The Community Inclusion/Integrated Settings KPA workgroup will develop, initiate, and monitor performance measures with a set target. Measures may be selected from, but not limited to, any of the following data sets: Employment; Community Engagement/Inclusion; QSRs; Housing; Regional Support Teams; Home and Community-Based Settings; NCI – (i.e., Individual Outcomes); WaMS	Met*
37.21: The Provider Competency and Capacity KPA workgroup will finalize surveillance data to be collected for "access to services," at minimum including: a. For individuals on the waitlist, length of time on the waitlist and priority level, as well as whether crisis services, Individual and Family Support Program funding, or a housing voucher have been received b. Ability to access transportation c. Provision of adaptive equipment for individuals with an identified need d. Service availability across geographic areas e. Cultural and linguistic competency	Met
37.22: The Provider Competency and Capacity KPA workgroup will develop, initiate, and monitor performance measures with a set target. Measures may be selected from, but not limited to, any of the following data sets: NCI – (i.e., System Performance); WaMS; Individual and Family Support Program (IFSP); Provider Data Summary; QSRs	Met*

V.D.3 Compliance Indicators	Status
37.23: The Provider Competency and Capacity KPA workgroup will finalize surveillance data to be collected for "Provider capacity," at minimum including: a. Staff receipt of competency-based training b. Demonstration of competency in core competencies c. Demonstration of competency in elements of service for the individuals they serve	Met
37.24: The Provider Competency and Capacity KPA workgroup will develop, initiate, and monitor performance measures with a set target. Measures may be selected from, but not limited to, any of the following data sets: Staff competencies; Staff training; QSRs; Provider Data Summary; QMRs; Licensing Citations	Met*

V.D.4 Compliance Indicators	Status
38.01: The Commonwealth collects and analyzes data from the following sources: a. Computerized Human Rights Information System (CHRIS): Serious Incidents – Data related to serious incidents and deaths. b. CHRIS: Human Rights – Data related to abuse and neglect allegations. c. Office of Licensing Information System (OLIS) – Data related to DBHDS-licensed providers, including data collected pursuant to V.G.3, corrective actions, and provider quality improvement plans. d. Mortality Review e. Waiver Management System (WaMS) – Data related to individuals on the waivers, waitlist, and service authorizations. f. Case Management Quality Record Review – Data related to service plans for individuals receiving waiver services, including data collected pursuant to V.F.4 on the number, type, and frequency of case manager contacts. g. Regional Education Assessment Crisis Services Habilitation (REACH) – Data related to the crisis system. h. Quality Service Reviews (QSRs) i. Regional Support Teams j. Post Move Monitoring Look Behind Data k. Provider-reported data about their risk management systems and QI programs, including data collected pursuant to V.E.2 l. National Core Indicators m. Training Center reports of allegations of abuse, neglect, and serious incidents	Not Met

V.D.5 Compliance Indicators	Status
39.01: The metrics listed for all portions of V.D.5 are predicated on the continued compliance of V.D.5.a for each RQC: "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."	Met
39.02: DBHDS has a charter for Regional Quality Councils ("RQCs") that describes the standard operating procedures as described in indicator V.B.4.d. DBHDS orients at least 86% of RQC members based on the charter and on quality improvement, data analysis, and related practices.	Met
39.03 Each DBHDS Region has convened a RQC that serves as a subcommittee to the QIC as described in indicator V.B.4.	Met
39.04: DBHDS prepares and presents relevant and reliable data to the RQCs which include comparisons with other internal or external data, as appropriate, as well as multiple years of data (as it becomes available).	Not Met
39.05: Each RQC reviews and assesses (i.e., critically considers) the data that is presented to identify: a) possible trends; b) questions about the data; and c) any areas in need of quality improvement initiatives, and identifies and records themes in meeting minutes. RQCs may request data that may inform quality improvement initiatives and DBHDS will provide the data if available. If requested data is unavailable, RQCs may	Not Met

V.D.5 Compliance Indicators	Status
make recommendations for data collection to the QIC.35.06: DMAS provides administrative oversight for the DD Waivers in compliance with its CMS-approved waiver plans, coordinates reporting to CMS, and conducts financial auditing consistent with the methods, scope and frequency of audits approved by CMS.	
V.D.5.b Compliance Indicators	**Status**
40.01: Each RQC meets quarterly with a quorum at least 3 of the 4 quarters with membership as outlined in the RQC charter. A quorum is defined as at least 60% of members or their alternates as defined in the RQC charter and must include representation from the following groups: the DBHDS QIC; an individual experienced in data analysis; a Developmental Disabilities (DD) service provider; and an individual receiving services or on the DD Waiver waitlist or a family member of an individual receiving services or on the DD Waiver waitlist.	Met
40.02: During meetings, conducted in accordance with its charter, the RQC reviews and evaluates data, trends, and monitoring efforts. Based on the topics and data reviewed, the RQC recommends at least one quality improvement initiative to the QIC annually.	Met*
40.03: Each RQC maintains meeting minutes for 100% of meetings. Meeting minutes are reviewed and approved by the membership of the RQC to ensure accurate reflection of discussion and evaluation of data and recommendations of the RQC.	Met
40.04: For each topic area identified by the RQC, the RQC a) decides whether more information/data is needed for the topic area, b) prioritizes a quality improvement initiative for the Region and/or recommends a quality improvement initiative to DBHDS, or c) determines that no action will be taken in that area.	Met
40.05: For each quality improvement initiative recommended by the RQC, at least one measurable outcome will be proposed by the RQC.	Not Met
40.06: 100% of recommendations agreed upon by the RQCs are presented to the DBHDS QIC.	Met
40.07: The DBHDS QIC reviews the recommendations reported by the RQCs and directs the implementation of any quality improvement initiatives upon approval by the QIC and the Commissioner. Relevant Department staff may be assigned to statewide quality improvement initiatives to facilitate implementation. The QIC directs the RQC to monitor the regional status of any statewide quality improvement initiatives implemented and report annually to the DBHDS QIC on the current status. The DBHDS QIC reports back to each RQC at least once per year on any decisions and related implementation of RQC recommendations. If the QIC declines to support a quality improvement initiative recommended by a RQC, the QIC shall document why.	Met

V.D.6 Compliance Indicators	Status
41.01: The Commonwealth posts reports, updated at least annually, on the Library Website or the DBHDS website on the availability and quality of services in the community and gaps in services and makes recommendations for improvement. Reports shall include annual performance and trend data as well as strategies to address identified gaps in services and recommendations for improvement strategies as needed and the implementation of any such strategies.	Not Met

V.D.6 Compliance Indicators	Status
41.02: Demographics – Individuals served a. Number of individuals by waiver type b. Number of individuals by service type c. Number of individuals by region d. Number of individuals in each training center, Number of children and adults with DD who were admitted to, or residing in, state operated psychiatric facilities f. Number of children residing in NFs and ICFs/IIDs, g. Number of adults residing in ICFs/IIDs and NFs (to the extent known) h. Number of individuals with DD (waiver and non-waiver) receiving Supported Employment i. Number of individuals with DD receiving crisis services by type, by region and disposition j. Number of individuals on the DD waiver waiting list by priority level, geographic region, age, and amount of time that individuals have been on the waiting list. k. Number of individuals in independent housing.	Not Met
41.03: Demographics – Service capacity a. Number of licensed DD providers i. Residential setting by size and type as defined by the Integrated Residential Services Report ii. Day services by type as defined by the Integrated Day Services Report b. Number of providers of Supported Employment and Therapeutic Consultation for Behavioral Support Services Number of providers of non-licensed services (e.g., supported employment, crisis) c. Number of ICF/IID non-state operated beds d. Number of independent housing options created	Not Met
35.04: The DBHDS Annual Quality Management Report and Evaluation includes the following information: a. An analysis of Data Reports, including performance measure indicators employed, an assessment of positive and negative outcomes, and performance that differs materially from expectations b. Key Performance Areas performance measures with set targets: 1. Health, Safety, and Well Being 2. Community Inclusion–Integrated Settings 3. Provider Capacity and Competency c. Case Management Steering Committee Report, Risk Management Review Committee Report e. Annual Mortality Review Report, including Quality Improvement Initiatives stemming from mortality reviews f. Quality Management Program Evaluation g. Planned quality improvement initiatives metrics h. Quality Improvement initiatives metrics employed i. Key Accomplishments of the Quality Management Program j. QI Committee, workgroup and council challenges, including positive and negative outcomes and/or performance measure indicators outcomes that differ materially from expectations. Challenges, including positive and negative outcomes and/or indications that performance is below expectations. k. Committee Performance l. A summary of areas reviewed by the Regional Quality Councils, along with recommendations and any strategies employed for quality improvement m. A summary of areas reviewed by the DBHDS Quality Improvement Committee (QIC), along with gaps identified, recommendations, and any strategies employed for quality improvement n. Recommendations and strategies for related improvement	Not Met
41.05: Additional information, including areas reviewed, and where available, gaps identified, recommendations, and strategies employed for quality improvement, and reports available: a. Results of licensing findings resulting from inspections and investigations b. Data Quality Plan c. Annual Quality Service Review d. Annual REACH Report on crisis system e. Semi-Annual Supported Employment Report f. RST Annual Report, including barriers to integrated services g. Semi-annual Provider Data Summary Report: provides information on geographic and population based disparities in service availability as well as barriers to services by region h. IFSP outcomes report and updates to IFSP Plan i. Integrated Residential Services Report j.	Not Met

V.D.6 Compliance Indicators	Status
Integrated Day Services Report k. DBHDS Annual Report l. National Core Indicators Annual Report and Bi-Annual National Report.	

V.E.1 Compliance Indicators	Status
42.01: DBHDS, through its regulations, requires DBHDS-licensed providers, including CSBs, to have a quality improvement (QI) program that: a. Is sufficient to identify, monitor, and evaluate clinical and service quality and effectiveness on a systematic and ongoing basis; b. Uses standard QI tools, including root cause analysis; c. Includes a QI plan that: i. is reviewed and updated annually, ii. defines measurable goals and objectives; DBHDS, through its regulations, requires DBHDS-licensed providers, including CSBs, to have a quality improvement (QI) program that: a. Is sufficient to identify, monitor, and evaluate clinical and service quality and effectiveness on a systematic and ongoing basis; b. Uses standard QI tools, including root cause analysis; c. Includes a QI plan that: i. is reviewed and updated annually, ii. defines measurable goals and objectives; iii. includes and reports on statewide performance measures, if applicable, as required by DBHDS; iv. monitors implementation and effectiveness of approved corrective action plans; and v. includes ongoing monitoring and evaluation of progress toward meeting established goals and objectives.	Not Met
42.02: DBHDS has published written guidance for providers on developing and implementing the requirements of 12 VAC 35-105-620 consistent with the regulation as in effect on October 1, 2019, including reviewing serious incidents as part of the quality improvement program, and will update and revise this guidance as necessary as determined by DBHDS.	Met
42.03 On an annual basis at least 86% of DBHDS licensed providers of DD services have been assessed for their compliance with 12 VAC 35-105- 620 during their annual inspections.	Not Met
42.04: On an annual basis, at least 86% of DBHDS-licensed providers of DD services are compliant with 12 VAC 35-105-620. Providers that are not compliant have implemented a Corrective Action Plan to address the violation.	Not Met
42.05: DBHDS has policies or Departmental Instructions that require Training Centers to have quality improvement programs that: a. Are reviewed and updated annually; b. Has processes to monitor and evaluate quality and effectiveness on a systematic and ongoing basis; c. Use standard quality improvement tools, including root cause analysis; d. Establish facility-wide quality improvement initiatives; and e. Monitor implementation and effectiveness of quality improvement initiatives.	Not Met

V.E.2 Compliance Indicators	Status
43.01: DBHDS requires regular reporting, at least annually, of each provider reporting measure from DBHDS-licensed DD providers. Measures referenced in indicators #1.c are reported quarterly. 86% of such providers report the measure as required.	Not Met
43.02: The DBHDS Office of Data Quality and Visualization assists with analysis of each provider reporting measure to ensure that the data sources are valid, identify what the potential threats to validity are, and ensure that the provider reporting measures are well-defined and measure what they purport to measure. The QIC or designated subgroup will review and assess each provider reporting measure annually and update accordingly.	Not Met

43.03: Provider reporting measures are monitored and reviewed by the DBHDS Quality Improvement Committee ("QIC") at least semi-annually, with input from Regional Quality Councils, described in Section V.D.5. Based on the semi-annual review, the QIC identifies systemic deficiencies or potential gaps, issues recommendations, monitors the measures, and makes revisions to quality improvement initiatives as needed, in accordance with DBHDS's Quality Management System as described in the indicators for V.B.	Not Met

V.E.3 Compliance Indicators	**Status**
44.01: In addition to monitoring provider compliance with the DBHDS Licensing Regulations governing quality improvement programs (see indicators for V.E.1), the Commonwealth assesses and makes a determination of the adequacy of providers' quality improvement programs through the findings from Quality Service Reviews, which will assess the adequacy of providers' quality improvement programs to include: a. Development and monitoring of goals and objectives, including review of performance data. b. Effectiveness in either meeting goals and objectives or development of improvement plans when goals are not met. c. Use of root cause analysis and other QI tools and implementation of improvement plans.	Not Met
44.02: Using information collected from licensing reviews and Quality Service Reviews, the Commonwealth identifies providers that have been unable to demonstrate adequate quality improvement programs and offers technical assistance as necessary. Technical assistance may include informing the provider of the specific areas in which their quality improvement program is not adequate and offering resources (e.g., links to on-line training material) and other assistance to assist the provider in improving its performance.	Not Met

IX.C	**Status**
54.01: The Commonwealth maintains a written index that identifies the records sufficient to document that the requirements of the Settlement Agreement are being implemented and the entities responsible for monitoring and ensuring that the records are made available ("Record Index").	Not Met
54.02 The Record Index specifies the following components for each record: • Identification and documentation of record locations • Timeframe for collecting and updating records as specified in the Settlement Agreement or as determined by DBHDS Identification of a custodian of the records who is responsible for oversight of the collection, storage, and updates • A process to monitor/audit record completion.	Not Met
54.03 The Record Index and all associated documents are timely available to the Independent Reviewer upon request.	Not Met
54.04: Records will be maintained in accordance with applicable Library of Virginia Records Retention and Disposition Schedules or longer, as necessary to demonstrate compliance with the Settlement Agreement. demonstrate adequate quality improvement programs and offers technical assistance as necessary. Technical assistance may include informing the provider of the specific areas in which their quality improvement program is not adequate and offering resources (e.g., links to on-line training material) and other assistance to assist the provider in improving its performance.	Not Met

V.C.4 Analysis of 19th Review Period Findings

Section V.C.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.

Compliance Indicator	Facts	Analysis	Conclusion
32.01: DBHDS will make training and topical resources available to providers on each of the following topics with an application to disability services, or at minimum to human services: a. proactively identifying and addressing risks of harm b. conducting root cause analysis c. developing and monitoring corrective actions.	DBHDS had made available training and topical resources available to providers on each of the following topics: a. proactively identifying and addressing risks of harm b. conducting root cause analysis c. developing and monitoring corrective actions.	At the time of the 17th Period review, DBHDS had made available training and topical resources available to providers on each of the following topics a. proactively identifying and addressing risks of harm b. conducting root cause analysis c. developing and monitoring corrective actions. For this review, some of the resources remained current, but DBHDS had updated others and issued some new materials. For example, at the time of the previous review, DBHDS had recently contracted with Center for Developmental Disabilities Evaluation and Research (CDDER) at the University of Massachusetts Shriver Center to make risk management training available to providers including on-line risk management modules in four areas: (1) Risk Screening, (2) Root Cause Analysis, (3) Incident Management, and (2) Data Analysis for Quality Improvement. For this review, the CDDER on-line courses were available and approved providers received one free enrollment per course. The following describes the current offerings: Proactively identifying and addressing risks of harm: • CDDER Risk Screening in Developmental Disabilities • Health & Safety Alerts, Courses and Educational Resources offered on the Office of Integrated Health (OIH) webpage. Examples included: o Dysphagia Health & Safety Alert – August 2021 o Urinary Tract Infection Health & Safety Alert – March 2021 o Sepsis Health & Safety Alert – January 2021 o Health Risks, including Aspiration Pneumonia, Constipation and Bowel Obstruction, Dehydration, Falls, Injury, Seizures, Sepsis o Risk Management Plan Conducting Root Cause Analysis:	17th Met 19th Met

Compliance Indicator	Facts	Analysis	Conclusion
		• Systemic Risk Assessment • SAMPLE Provider Systemic Risk Assessment - June 2021 • Risk Management Quality Improvement Tips and Tools - June 2021 • Root Cause Analysis Training – October/November 2020 • CDDER Risk Management & Quality Improvement Strategies – December 2020 (webinar recording) • CDDER Root Cause Analysis in Developmental Disabilities • Other educational resources included guidance on root cause analysis: o Questions and Answers from QI-RM-RCA Training November 2020 - January 2021 o Guidance for Serious Incident Reporting – effective 11/28/20 ; o Final Licensing Regulations – October 2020 Developing and monitoring corrective actions: • Guidance on Corrective Action Plans – effective 8/22/20 • CDDER Risk Management & Quality Improvement Strategies – December 2020 • Final Licensing Regulations – October 2020 • Guidance for a Quality Improvement Program - November 2020 • Questions and Answers from QI-RM-RCA Training November 2020 (January 2021) • Risk Management Quality Improvement Tips and Tools - June 2021	
32.02: Training(s) or educational resources in each topical area identified in Indicator 1 will be made available to providers through the DBHDS website, or other on-line systems.	For this review, training and topical resource reference materials continued to be available on the Commonwealth of Virginia's Learning Center (COVLC), through the CDDER on-line courses and/or	For this review, training and topical resource reference materials continued to be available on the Commonwealth of Virginia's Learning Center (COVLC), through the CDDER on-line courses and/or on the DBHDS Office of Integrated Health website. When new or revised information is made available on the web, a notice is sent to all subscribers to the DBHDS Listserv. At the time of the previous review, DBHDS staff reported that a project had been initiated to place training modules into the Department's Learning Management System, which has the capability to track providers that access and successfully complete the training. While this would be a significant advantage for longitudinal analysis of the	17th Met 19 h Met

Compliance Indicator	Facts	Analysis	Conclusion
	on the DBHDS Office of Integrated Health website. When new or revised information is made available on the web, a notice is sent to all subscribers to the DBHDS Provider Listserv.	effectiveness of the training, for this review, DBHDS staff reported that no significant progress had been made.	
32.03: Providers that have been determined to be non-compliant with risk management requirements (as outlined in V.C.1, indicator #4) for reasons that are related to a lack of knowledge, will be required to demonstrate that they complete training offered by the Commonwealth, or other training determined by the Commonwealth to be acceptable, as part of their corrective action plan.	DBHDS provided a document entitled *Crosswalk of DBHDS Approved Risk Management Training* that described the process by which licensed providers should implement the DBHDS Risk Management (RM) Attestation process to demonstrate that they completed requisite training. DBHDS provided spreadsheets for this review showing noncompliant providers, but did not show if/when the corrective action plan was received,	At the time of the 17th Period review, The Office of Licensing had recently developed and implemented an *Internal Protocol for Assessing Compliance with 12VAC35-105-520* that provided specific instructions to licensing specialists about how to identify and cite providers found not to be compliant with the risk management requirements due to lack of knowledge. The instructions state "The Provider shall demonstrate that they completed training offered by the Commonwealth, or other training determined by the Commonwealth to be acceptable, as part of their corrective action plan." It was anticipated that this guidance to licensing specialists would increase consistency in their compliance assessments and ensure that corrective action plans contained completion of required training as an element of the correction. At that time, DBHDS has not had sufficient time to assess and determine that providers have demonstrated that they have completed the training. For this review, DBHDS provided a document entitled *Crosswalk of DBHDS Approved Risk Management Training* that described the process by which licensed providers should implement the DBHDS Risk Management (RM) Attestation process to demonstrate that they completed requisite training .The document provided a crosswalk of DBHDS approved trainings that would fulfill the requirements of *12 VAC35-105-520.A.* and attached an attestation form. The document further instructed that, upon completion of any required training, the attestation form was to be read, signed and dated by the person designated as responsible for the risk management function for the provider as well as that person's direct supervisor. Further, the form did not need to be	17th Not Met 19th Not Met

Compliance Indicator	Facts	Analysis	Conclusion
	implemented or completed.	submitted directly to the Office of Licensing when completed, but rather kept on file and presented when requested by the Office of Licensing, including when requested during onsite and remote inspections. DBHDS provided spreadsheets showing noncompliant providers (i.e., *520A 1-1-2021 to 9-7-2021 DW-0085-Key Licensing Regulatory Compliance Report* and *520A-E January 1-2021 to 9-7-2021 DW-0085-Key Licensing Regulatory Compliance Report*). For each non-compliant provider, the reports included an action step to "write corrective action plan." However, the spreadsheets did not show if the corrective action plan included the completion of staff training or if/when the corrective action plan was received, implemented or completed. The spreadsheets were received too late in the review period to allow follow-up with DBHDS staff to request additional information that might have clarified if corrective action plans were received, implemented or completed, and too late to allow time to schedule and complete planned sampling of provider interviews and records.	
32.04: Providers that have been determined to be non-compliant with requirements about training and expertise for staff responsible for the risk management function (as outlined in V.C.1, indicator #1.a) and providers that have been determined to be non-compliant with requirements about conducting root cause analyses as required by 12 VAC 35-105-160(E) will be required to demonstrate that they complete training offered	DBHDS provided a document entitled *Crosswalk of DBHDS Approved Risk Management Training* that described the process by which licensed providers should implement the DBHDS Risk Management (RM) Attestation process to demonstrate that they completed requisite training. A spreadsheet DBHDS provided for this review showed noncompliant providers, but did not	At the time of the 17th Period review, the Office of Licensing had recently developed and implemented the aforementioned *Internal Protocol for Assessing Compliance with 12VAC35-105-520* that provided specific instructions to licensing specialists about how to identify and cite providers found not to be compliant with the requirement to conduct a Root Cause Analysis for any Level 2 or Level 3 incidents. This guidance required that any corrective action plan for a citation for violation of 12VAC35-105-160.E (RCA for Level 2 or Level 3 incidents) must include "completion of training offered by the Commonwealth, or other training determined by the Commonwealth to be acceptable, as part of their corrective action plan. Department-approved training will be posted on the Office of Licensing webpage." DBHDS staff reported at that time they anticipated that this guidance would increase consistency in their compliance assessments and assurance that corrective action plans contain the requirement to complete required training as an element of the correction. At that time, DBHDS had not had sufficient time to assess and determine that providers have demonstrated that they have completed the training. For this review, DBHDS provided a document entitled *Crosswalk of DBHDS Approved Risk Management Training* that described the process by which licensed providers should implement the DBHDS Risk Management (RM) Attestation process to demonstrate	17th Not Met 19th Not Met

Compliance Indicator	Facts	Analysis	Conclusion
by the Commonwealth, or other training determined by the Commonwealth to be acceptable, as part of their corrective action plan process.	show if/when the corrective action plan was received, implemented or completed.	that they completed requisite training. The document provided a crosswalk of DBHDS approved trainings that would fulfill the requirements of *12 VAC35-105-520.A.* and attached an attestation form. The document further instructed that, upon completion of any required training, the attestation form was to be read, signed and dated by the person designated as responsible for the risk management function for the provider as well as that person's direct supervisor. Further, the form did not need to be submitted directly to the Office of Licensing when completed, but rather kept on file and presented when requested by the Office of Licensing, including when requested during onsite and remote inspections. The documentation DBHDS provided for this review consisted of a spreadsheet showing noncompliant providers (i.e., *160.E 1-1-2021 to 9-7-2021 DW-0085-Key Licensing Regulatory Compliance Report*). For each non-compliant provider, the report included an action step to "write corrective action plan." However, the spreadsheet did not show if the corrective action plan included the completion of staff training or if/when the corrective action plan was received, implemented or completed. The spreadsheet was received too late in the review period to allow follow-up with DBHDS staff to request additional information that might have clarified if corrective action plans received, implemented or completed, and too late to allow time to schedule and complete planned sampling of provider interviews and records.	
32.05: DBHDS offers written guidance to providers (including residential, day/employment, and case management) on how to proactively identify and address risks of harm. This content will include: a. Guidance on conducting individual-level risk screening b. Either a tool for risk	DBHDS offered written guidance and training materials that addressed each of the criteria for CI 32.05 a. through c.	At the time of the 17th Period review, DBHDS had offered written guidance to providers (including residential, day/employment, and case management) on how to proactively identify and address risks of harm, including content covering the following: a. Guidance on conducting individual-level risk screening; b. Either a tool for risk screening selected by DBHDS or example resources for consideration by providers to use when conducting risk screening; c. Guidance on how to incorporate identified risks for individual service recipients into service planning and how to adequately address the risks. For this review, some of the resources remained current, but DBHDS had updated others and issued some new materials. The following describes the current offerings: • CDDER Risk Screening in Developmental Disabilities • DBHDS Information on Risk Awareness Tool	17th Met 19th Met

Compliance Indicator	Facts	Analysis	Conclusion
screening selected by DBHDS or example resources for consideration by providers to use when conducting risk screening c. Guidance on how to incorporate identified risks for individual service recipients into service planning and how to adequately address the risks.		• Risk Awareness Tool training on COVLC • Risk Awareness Tool • Risk Awareness Tool –Frequently Asked Questions • Downloadable PowerPoint Training on Specific Health Risks on the OIH webpage for specific health risks Taken together, the written guidance and training materials addressed each of the criteria for CI 32.05 a. through c.	
32.06: DBHDS publishes detailed guidance, with input from relevant professionals, about risks common to people with developmental disabilities, which include considerations for how to appropriately and adequately monitor, assess, and address each risk. DBHDS will review its content annually and revise as necessary to ensure current guidance is sufficient and is included in each alert.	DBHDS had published written guidance to providers about risks common to people with developmental disabilities, which include considerations for how to appropriately and adequately monitor, assess, and address each risk. These included training materials for seven common risks, as well as a series of Health and Safety Alerts on such topics. As evidence to show it reviewed its content annually and revised as	At the time of the 17th Period review, DBHDS had published written guidance to providers about risks common to people with developmental disabilities, which include considerations for how to appropriately and adequately monitor, assess, and address each risk. These continue to be available, including on-line guidance for the following health risks: • Aspiration Pneumonia • Constipation and Bowel Obstruction • Dehydration • Falls • Pressure Injury Training • Seizures • Sepsis • Comprehensive Risk Management Plan For this review, the OIH also continued to provide updated and new Health and Safety Alerts. As examples for this review period, new alerts published this year included the following: • Dysphagia Health & Safety Alert – August 2021 • Urinary Tract Infection Health & Safety Alert – March 2021 • Sepsis Health & Safety Alert – January 2021	17th Met 19th Met

Compliance Indicator	Facts	Analysis	Conclusion
	necessary to ensure current guidance is sufficient and is included in each alert, DBHDS submitted three Biannual Reviews of DBHDS Health and Safety Alerts for June 2020, December 2020 and June 2021.	DBHDS also submitted evidence to show it reviewed its content annually and revised as necessary to ensure current guidance is sufficient and is included in each alert. Based on review of RMRC minutes and attachments, the OIH took the lead in conducting a review of Health & Safety Alerts to ensure that the information was still accurate and provided a summary of the reviews and recommendations for removal and updating. DBHDS submitted three Biannual Review of DBHDS Health and Safety Alerts for June 2020, December 2020 and June 2021.	
32.07: DBHDS will use data and information from risk management activities, including mortality reviews to identify topics for future content; make determinations as to when existing content needs to be revised; and identify providers that are in need of additional technical assistance or other corrective action. Content will be posted on the DBHDS website and the DBHDS provider listserv. Guidance will be disseminated widely to providers of services in both licensed and unlicensed settings, and	RMRC used data and information from risk management activities, including mortality reviews to identify topics for future content. DBHDS did not provide specific protocol or procedures to describe how it uses data and information from risk management activities, including mortality reviews to identify topics for future content; make determinations as to when existing content needs to be revised; and identify providers that are in need of	For the previous review period, the study found that the RMRC met monthly and reviewed relevant data, information and related processes associated with risk management. This continued to be true for this review period. Examples below illustrate how the RMRC used data and information from risk management activities, including mortality reviews to identify topics for future content: • Based on the RMRC review of data for 327 UTI reports, from the period 10/1/19 through 9/30/20, in March 2021, OIH published an updated Health and Safety Alert on Urinary Tract Infections, and focused on National Kidney Month in the OIH Health Trends Newsletter. In addition, they made plans to review and update existing provider training and educational resources (e.g., atypical signs and symptoms of UTI; Skill building related to personal care/hygiene; discussing body parts; health literacy; how other diagnoses, diseases, and medications interplay with a diagnosis of a UTI, etc.) • The MRC reported its MRC Sepsis Awareness QII resulted in the provision of Sepsis Training to 201 participants on 6/4/21. In addition, as noted with regard to CI 32.06 above, in January 2021, the OIH published a Health and Safety Alert on the topic. However, for this review, DBHDS did not provide specific protocol or procedures to describe how it uses data and information from risk management activities, including mortality reviews to identify topics for future content; make determinations as to when existing content needs to be revised; and identify providers that are in need of additional technical assistance or other corrective action. A review of the RMRC Charter, the	17th Not Met 19th Not Met

Compliance Indicator	Facts	Analysis	Conclusion
to family members and guardians.	additional technical assistance or other corrective action. Therefore, DBHDS did not show it has in place a minimum set of finalized policies, procedures, instructions, protocols and/or tools that will be needed for the Independent Reviewer to formulate his determinations as to whether this CI has been met and the Provisions achieved, and to determine if DBHDS has them in place. As described with regard to CI 36.01 and 38.01, DBHDS had not yet ensured available data were valid and reliable, so the data cannot be used to confirm compliance at this time.	Quality Management Plan and Departmental Instruction 316 revealed that they indicate the RMRC will undertake these activities, but do not provide any procedures or protocol for how these tasks will be implemented (e.g., designation of responsibilities, timeframes for implementation, how guidance would be disseminated widely to family members and guardians, etc.). The lack of specific documentation might have been an oversight on their part, as it appeared that they undertook activity in some of these areas (e.g., OIH undertook the review and determinations as to when existing content needed to be revised and reported this to the RMRC for approval, DBHDS posted content on its website, etc.). Going forward, as required by the Court in his April 2019 order, DBHDS should ensure it has in place a minimum set of finalized policies, procedures, instructions, protocols and/or tools sufficient to document proper implementation of the Settlement Agreement, and to post such documents on its Library for the Independent Reviewer to formulate his determinations whether the CIs have been met and the Provisions achieved, and to determine if DBHDS had them in place. In addition, as described with regard to CI 36.01 and 38.01, DBHDS had not yet ensured available data were valid and reliable, so DBHDS could not show that the data used for these purposes was sufficient to support accurate decision-making and cannot be used to confirm compliance at this time.	

Compliance Indicator	Facts	Analysis	Conclusion
32.08: DBHDS offers written guidance to providers on conducting root cause analysis, and assesses that providers adequately (in accordance with DBHDS's own guidance) identify cases for and conduct root cause analysis.		At the time of the 17th Period review, DBHDS was offering written guidance to providers on conducting root cause analysis, and assessed that providers adequately (in accordance with DBHDS's own guidance) identify cases for and conduct root cause analysis. For this review, some of the resources remained current, but DBHDS had updated others and issued some new materials. The following describes the current offerings: • Guidance for Serious Incident Reporting – effective 11/28/20 • Final Licensing Regulations – October 2020 • Root Cause Analysis Training – October/November 2020 • Questions and Answers from QI-RM-RCA Training November 2020 – January 2021 • Risk Management & Quality Improvement Strategies CDDER – December 2020 • Risk Management & Quality Improvement Strategies CDDER – December 2020 • Root Cause Analysis in Developmental Disabilities – CDDER on-line course At the time of the 17th Period review, the study found that the Office of Licensing assessed that providers adequately identified cases for and conducted root cause analyses as a part of the annual licensing inspection. DBHDS had issued guidance to licensing specialists entitled *Office of Licensing Internal Protocol for Assessing Serious Incident Reporting by Providers of Developmental Services* on 10/01/2020 regarding this assessment process. This guidance includes protocols for review and determination of compliance with requirements to conduct root cause analyses as specified in 12VAC35-105- 160E. The guidance also includes a requirement for a Corrective Action Plan (CAP) for any cited violations including those related to conducting root cause analyses. For this review, DBHDS submitted a document entitled *Assessment of Providers Conducting RCA*. It stated the following: "Regulation 160.E states that providers shall conduct a root cause analysis within 30 days of a level II or level III serious incident that occurs during the provision of services or on the provider's premises. The data above shows that there were a total of 678 annual inspections during the time period; and that licensing	17th Met 19th Met

Compliance Indicator	Facts	Analysis	Conclusion
		specialists assessed provider's compliance with regulation 160.E on 632 of those inspections (or 93%). It further shows that licensing specialists, were unable to make a compliance determination in 180 of these inspections; and that they determined that providers were compliant with this requirement in 413 of the 452 (91%) inspections in which a determination could be made." DBHDS also submitted a document entitled *OL Annual Checklist Compliance Determination Chart , FY 2021*, dated 4.29.21 that described the processes by which DBHDS licensing staff completed such assessments.	
32.09: DBHDS offers written guidance to providers, including example scenarios, on developing, implementing, and monitoring corrective actions they identify as necessary, as well as identified solutions to mitigate the re-occurrence of serious incidents. This guidance will instruct providers to document their plans for corrective actions resulting from regulatory citations, root cause analyses, or other risk management or quality improvement activities; as well as their actions taken and any related decisions		At the time of the 17th Period review, DBHDS was offering written guidance to providers including example scenarios, on developing, implementing, and monitoring corrective actions they identify as necessary, as well as identified solutions to mitigate the re-occurrence of serious incidents. For this review, DBHDS provided links to the following guidance documents: • Guidance on Corrective Action Plans – effective 8/22/20 • Risk Management & Quality Improvement Strategies CDDER – December 2020 • Final Licensing Regulations – October 2020 • Guidance for a Quality Improvement Program – November 2020 • Questions and Answers from QI-RM-RCA Training November 2020 – January 2021 • Risk Management Quality Improvement Tips and Tools – June 2021 Based on review of the documents provided, DBHDS met the criteria requiring that the guidance instruct providers to document their plans for corrective actions resulting from regulatory citations, root cause analyses, or other risk management or quality improvement activities; as well as their actions taken and any related decisions to deviate from planned actions.	17th Met 19th Met

Compliance Indicator	Facts	Analysis	Conclusion
to deviate from planned actions.			

V.D.1 Analysis of 19th Review Period Findings

Section V.D.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.

Compliance Indicator	Facts	Analysis	Conclusion
35.01: The Commonwealth implements the Quality Improvement Plan approved by CMS in the operation of its HCBS Waivers.		The Commonwealth was not fully implementing the requirements of the Quality Improvement Plan approved by CMS. The following examples of deficiencies were noted: • Appendix H states that the Office of DQV assists DBHDS programs that provide data to the QRT to identify, evaluate, refine, and document processes that already exist in their respective areas, as well as assists in determining where improvements are needed and establishing a plan for monitoring data quality, which is then reported back to the QRT and/or the QIC. In addition, Appendix H states that "each (DBHDS) quality improvement subcommittee reports on targeted performance measure indicators (PMI's), which allow for tracking the efficacy of preventative, corrective and improvement initiatives, and are used to prioritize quality improvement initiatives within the state. The PMI's are aligned with the performance measures under the waiver assurances and used to ensure consistency and accountability of performance statewide." As described below with regard to CI 35.03, for the PMIs for which DBHDS	17th Met 19th Not Met

Compliance Indicator	Facts	Analysis	Conclusion
		provides data for QRT review, data that are not determined to be reliable and valid cannot be used to effectively prioritize quality improvement initiatives. • The Waiver Quality Improvement Plan includes Performance Measure C9: number and percent of provider agency direct support professionals (DSPs) meeting competency training requirements. As described below, this study found that DMAS did not implement sufficient discovery activities to ensure the Commonwealth collected data to accurately measure performance or identify and implement any needed remediation, as it related to CI 49.02 (i.e., requiring DSPs and DSP Supervisors, including contracted staff, providing direct services to meet the training and core competency requirements contained in DMAS regulation 12VAC30-122-180, including demonstration of competencies specific to health and safety within 180 days of hire), CI 49.03 (i.e., requiring DSPs and DSP Supervisors who have not yet completed training and competency requirements per the regulation to be accompanied and overseen by other qualified staff for the provision of any direct services), and CI 49.04 (i.e., requiring that at least 95% of DSPs and their supervisors receive training and competency testing)	
35.02: The CMS-approved Quality Improvement Plan in the DD HCBS waivers outlines: a. Inclusion of the evidence-based discovery activities that will be conducted for each of the six major waiver assurances. b. The remediation activities followed to correct individual problems identified in the implementation of each of the assurances.	For CI 35.02, the CMS-approved Quality Improvement Plan in the DD HCBS waivers outlined each of the requirements a. through i.	As reported at the time of the 17th Period review, for this review, the CMS-approved Quality Improvement Plan in the DD HCBS Waivers outlined each of the requirements a. through i. a. Evidence-based discovery activities (KPAs, Domains and Performance Measure Indicators) in eight Quality of Life and Provider Service domains that incorporate data and information related to each of the six major waiver assurances – (1) Level of care, (2) Service planning and delivery, (3) Qualified providers, (4) Health and safety, (5) Fiscal accountability, and (6) Quality improvement. b. Outline of the process for remediation of individual problems in the implementation of each of the discovery activities c. Assignments of responsibility for each of the performance measures including data collection, analysis, and reporting d. Description of the oversight processes for each of these areas including reporting requirements culminating in final review each quarter by the Waiver Quality Review Team (QRT).	17th Met 19th Met

Compliance Indicator	Facts	Analysis	Conclusion
c. Identification of the Department and Division responsible for overall management of the respective QM function(s). DMAS, as the Single State Medicaid Agency, retains overall authority for the operation of the DD HCBS waivers in their entirety. d. Processes to oversee and monitor all components related to the QM Strategy. e. Identification of performance measures that will be assessed. f. Processes to review performance trends, patterns, and outcomes to establish quality improvement priorities. g. Processes to recommend changes to policies, procedures and practices, waivers, and regulation as informed through ongoing review of data. h. Processes to ensure remediation activities are completed and to evaluate their effectiveness. i. Processes to report progress and		e. Identification of specific performance measures for each identified KPA and Domain area. f. Responsibilities of the individual departments and various committees and councils to collect, analyze and report relevant data and information to the QRT to review results (trends, patterns and outcomes) of data collected and analyzed for each performance measure. g. Responsibilities of the QRT to recommend policy and/or procedural changes related to identified concerns from the quarterly review and analysis of the data, trends, patterns and outcomes h. Responsibilities of the QRT to review and assure successful completion of remediation activities and/or to identify new or additional remediation needed. i. Processes to report progress and recommendations to the QIC.	

<table>
<tr><th>Compliance Indicator</th><th>Facts</th><th>Analysis</th><th>Conclusion</th></tr>
<tr><td>recommendations to the QIC.</td><td></td><td></td><td></td></tr>
<tr><td>35.03 The Commonwealth has established performance measures, reviewed quarterly by DMAS and DBHDS, as required and approved by CMS in the areas of: a. health and safety and participant safeguards, b. assessment of level of care, c. development and monitoring of individual service plans, including choice of services and of providers, d. assurance of qualified providers, e. whether waiver enrolled individuals' identified needs are met as determined by DMAS QMR, f. identification, response to incidents, and verification of required corrective action in response to substantiated cases of abuse/neglect/exploitation (prevention is contained in corrective action plans).</td><td>Based on a review of the HCBS waivers, the Commonwealth has established performance measures as required and approved by CMS for each of the areas defined in CI 35.03, sub-indicators a. through f.

DBHDS provided a set of charts that showed they QRT demonstrated the QRT reviewed performance data for each of the measures.

However, CI 36.01 of the Settlement Agreement (SA) requires that data sources will not be used for compliance reporting until they have been found to be valid and reliable. Based on the findings for CI 36.01 and CI 38.01 below, for those measures for which</td><td>At the time of the 17th Period review, the QRT, a joint DBHDS and DMAS committee, monitored and evaluated data related to the CMS assurances and sub-assurances outlined in the DD waivers. In addition, minutes of the quarterly QRT meetings reflected their review of activities and reporting of the data related to each performance indicator.

For this review period, based on a review of the HCBS waivers, the Commonwealth has established performance measures as required and approved by CMS for each of the areas defined in CI 35.03 (i.e., sub-indicators a. through f.)
With the understanding that data that have not been determined to be reliable and valid cannot be used to effectively identify needed actions, such as establishing priorities for quality improvement initiatives or identifying priority areas for remediation, the table below lists the established performance measures by sub-indicator, and indicates in bold type the data source for those measures for which DBHDS provides the performance data:

<table><tr><th>Performance Area</th><th>Performance Measures</th></tr><tr><td>a. Health and safety and participant safeguards,</td><td>Performance Measure G1. Number and percent of closed cases of abuse/neglect/exploitation for which DBHDS verified that the investigation conducted by the provider was done in accordance with regulations. (DBHDS via CHRIS - OHR)</td></tr><tr><td></td><td>Performance Measure G2. Number and percent of substantiated cases of abuse/neglect/exploitation for which the required corrective action was verified by DBHDS as being implemented. (w/in 90 days) (DBHDS via CHRIS - OHR)</td></tr><tr><td></td><td>Performance Measure G3. Number and percent of unexpected deaths where the cause of death, or a factor in the death, was potentially preventable and some intervention</td></tr></table></td><td>17th Met

19th Not Met</td></tr>
</table>

Compliance Indicator	Facts	Analysis			Conclusion
	DBHDS provided performance data, DBHDS had not yet determined that the data were valid and reliable and, therefore, may not be used for compliance reporting.			to remediate was taken. (**DBHDS – Mortality Review Committee Data Tracking**)	
				Performance Measure G4. Number and percent of individuals who receive annual notification of rights and information to report ANE	
				Performance Measure G5. Number and percent of critical incidents reported to the Office of Licensing within the required timeframes as specified in the approved waiver. (**DBHDS via CHRIS - SIR**)	
				Performance Measure G6. # and % of licensed DD providers that administer medications that were not cited for failure to review medication errors at least quarterly. (**DBHDS -not specified and no PMI provided**)	
				Performance Measure G7. Number and percent of individuals reviewed who did not have unauthorized restrictive interventions. (**DBHDS QSR Contractor alerts**)	
				Performance Measure G8. Number and percent of individuals who did not have unauthorized seclusion. (**DBHDS via CHRIS - SIR**)	
				Performance Measure G9. Number and Percent of participants 20years and older who had an ambulatory or preventive care visit during the year.	
			b. Assessment of level of care	Performance Measure B1: Number and percent of all new enrollees who have a level of care evaluation prior to receiving waiver services (**DBHDS WaMS via DW_0079**)	
				Performance Measure B2: The number and percent of VIDES (LOC) completed within 60 days of application for those for whom there is	

Compliance Indicator	Facts	Analysis			Conclusion
				a reasonable indication that service may be needed in the future (**DBHDS -WaMS via DW_0078**)	
				Performance Measure B3: Number and percent of VIDES determinations that followed the required process, defined as completed by a qualified CM, conducted face-to-face with the individual and those who know him (if needed).	
				Performance Measure B4: Number and percent of VIDES determinations for which the appropriate number of criteria were met to enroll or maintain a person in the waiver.	
			c. Development and monitoring of individual service plans, including choice of services and of providers	Performance Measure D1: Number and percent of individuals who have Plans for Support that address their assessed needs, capabilities and desired outcomes. (DMAS)	
				Performance Measure D2: Number and percent of individual records that indicate that a risk assessment was completed as required.	
				Performance Measure D3: Number and percent of individuals whose Plan for Supports includes a risk mitigation strategy when the risk assessment indicates a need.	
				Performance Measure D4: Number and percent of service plans that include a back-up plan when required for services to include in-home supports, personal assistance, respite, companion, and Shared Living.	
				Performance Measure D5: Number and percent of service plans reviewed and revised by the case manager by the individual's annual review date.	
				Performance Measure D6: Number and percent of individuals whose service plan was revised, as needed, to address changing needs.	

Compliance Indicator	Facts	Analysis			Conclusion
				Performance Measure D7: Number and percent of individuals who received services in the frequency specified in the service plan	
				Performance Measure D8: Number and percent of individuals who received services in the duration specified in the service plan	
				Performance Measure D9: Number and percent of individuals who received services in the type specified in the service plan	
				Performance Measure D10: Number and percent of individuals who received services in the scope specified in the service plan	
				Performance Measure D11: Number and percent of individuals who received services in the amount specified in the service plan	
				Performance Measure D12: Number and percent of individuals whose case management records documented that choice of waiver providers was provided to and discussed with the individual. (DMAS)	
				Performance Measure D13: Number and percent of individuals whose case management records contain an appropriately completed and signed form that specifies choice was offered among waiver services	
			d. Assurance of qualified providers	Performance Measure C1: Number and percent of licensed/certified waiver provider agency enrollments for which the appropriate license/certificate was obtained in accordance with waiver requirements prior to service provision.	
				Performance Measure C2: Number & percent of licensed/certified waiver provider agency staff who have criminal background checks as specified in policy/regulation with satisfactory results.	
				Performance Measure C3: Number & percent of enrolled licensed/certified provider	

Compliance Indicator	Facts	Analysis			Conclusion
				agencies, continuing to meet applicable licensure/certification following initial enrollment.	
				Performance Measure C4: Number and percent of non-licensed/noncertified provider agencies that meet waiver provider qualifications. (DMAS)	
				Performance Measure C5: Number & percent of non-licensed/noncertified provider agency DSPs who have criminal background checks as specified in policy/regulation with satisfactory results. (DMAS)	
				Performance Measure C6: Number of new consumer-directed employees who have a criminal background check at initial enrollment.	
				Performance Measure C7: # of consumer-directed employees who have a failed criminal background who are barred from employment (DMAS)	
				Performance Measure C8: Number and percent of provider agency staff meeting provider orientation training requirements (DMAS)	
				Performance Measure C9: Number and percent of provider agency direct support professionals (DSPs) meeting competency training requirements.	
				Performance Measure C10: Number of services facilitators meeting training requirements and passing competency testing.	
			e. Whether waiver enrolled individuals' identified needs are met as determined by DMAS QMR	Performance Measure D1: Number and percent of individuals who have Plans for Support that address their assessed needs, capabilities and desired outcomes. (DMAS)	
				Performance Measure D2: Number and percent of individual records that indicate that a risk assessment was completed as required.	

Compliance Indicator	Facts	Analysis		Conclusion
			Performance Measure D3: Number and percent of individuals whose Plan for Supports includes a risk mitigation strategy when the risk assessment indicates a need.	
			Performance Measure D4: Number and percent of service plans that include a back-up plan when required for services to include in-home supports, personal assistance, respite, companion, and Shared Living.	
			Performance Measure D7: Number and percent of individuals who received services in the frequency specified in the service plan	
			Performance Measure D8: Number and percent of individuals who received services in the duration specified in the service plan	
			Performance Measure D9: Number and percent of individuals who received services in the type specified in the service plan	
			Performance Measure D10: Number and percent of individuals who received services in the scope specified in the service plan	
			Performance Measure D11: Number and percent of individuals who received services in the amount specified in the service plan	
		f. Identification, response to incidents, and verification of required corrective action in response to substantiated cases of abuse/neglect/exploitation (prevention is contained in corrective action plans).	Performance Measure G2: Number and percent of closed cases of abuse/neglect/exploitation for which the required corrective action was verified by DBHDS as being implemented	
			Performance Measure G4: Number and percent of individuals who receive annual notification of rights and information to report ANE	

Compliance Indicator	Facts	Analysis	Conclusion
		For this review, with regard to quarterly review of the performance measures, DBHDS provided a document entitled *DOJ Settlement Agreement – Process Document*, dated 8/2/21. According to the process document, the interagency QRT process is the statewide mechanism for measuring the state's effectiveness in addressing non-compliance and low performance under its HCBS waivers program. The process document indicated that the QRT process is triggered by the end of a quarter for review of the previous quarter's data and noted there is a one quarter delay in reporting. As a result, the QRT review schedule is as follows: • In the first quarter of a fiscal year (FY) (i.e., 7/1-9/30) the QRT will review fourth quarter data from the prior FY. • In the second quarter of an FY (i.e., 10/1-12/31) the QRT will review first quarter data. • In the third quarter of an FY (i.e., 1/1-3/31), the QRT will review second quarter data. • In the fourth quarter of an FY (i.e., 4/1-6/30), the QRT will review of third quarter data. For this review period, to demonstrate the QRT reviewed the performance measures quarterly, DBHDS provided an *FY2021 3rd Quarter QRT Meeting Agenda*, dated 8/18/21, and another, also labelled *FY 2021 3rd Qtr. QRT Meeting Summary*, but dated 51/9/21. It appeared this might have been for the 2nd Quarter. Both documents included a chart that demonstrated the QRT reviewed performance data for each of the measures. However, CI 36.01 of the Settlement Agreement (SA) requires that data sources will not be used for compliance reporting until they have been found to be valid and reliable. Based on the findings for CI 36.01 and CI 38.01 below, for those measures for which DBHDS provided performance data, DBHDS had not yet determined that the data were valid and reliable and, therefore, may not be used for compliance reporting.	
35.04: The performance measures are found in the published DD HCBS waivers found at cms.gov	The waiver performance measures are found in the published DD HCBS	For this review, the study confirmed that the waiver performance measures are found in the published DD HCBS waivers found at cms.gov.	17th Met 19th Met

Compliance Indicator	Facts	Analysis	Conclusion
and are posted on the DBHDS website.	waivers found at cms.gov. DBHDS had posted on its website the QRT End of Year (EOY) report, which included the performance measures. While the published EOY report was dated (i.e., covering FY 19), the performance measures were the same as for the current year.	In addition, DBHDS had posted the SFY19 QRT End of Year (EOY) report on its website, which included the performance measures. While the published EOY report was dated, the performance measures were the same as those for this current period.	
35.05: Quarterly data is collected on each of the above measures and reviewed by the DMAS-DBHDS Quality Review Team. Remediation plans are written and remediation actions are implemented as necessary for those measures that fall below the CMS-established 86% standard. DBHDS will provide a written justification for each instance where it does not develop a remediation plan for a measure falling below 86%	DBHDS provided two sets of QRT minutes that demonstrated the QRT reviewed performance data for each of the measures. These minutes included reporting on remediation plans, but focused primarily on individual provider remediation rather than systemic remediation needs. The SFY 20 EOY Report provided	At the time of the 17th Period review, the study found that the QRT reviewed quarterly data as required, that remediation was noted for each of the indicators falling below the 86% threshold and that progressive remediation was noted for those who fell below the threshold for more than one quarter. However, while some remediation plans reflect a systemic focus, this was an area that needed continued effort to expand the scope and improve the impact of the remediation being implemented. In addition, the 17th Period study found that data review and analysis did not identify trends and patterns, the data definitions and source descriptions were not sufficient to ensure data reliability and "standard procedures" did not identify the data collection methodology at the source. For this review, DBHDS provided two sets of QRT minutes designated as 3rd Quarter, dated 5/19/21 and 8/18/21, that demonstrated the QRT reviewed performance data for each of the measures. These minutes included reporting on remediation plans, but these focused primarily on individual provider remediation. Overall, there continued to be a need to develop improvement and remediation plans that evidenced a focus on systemic factors. Even when the QRT acknowledged multiple providers that required remediation and listed a reason for the non-compliance, there	17th Not Met 19th Not Met

Compliance Indicator	Facts	Analysis	Conclusion
compliance. Quality Improvement remediation plans will focus on systemic factors where present and will include the specific strategy to be employed and defined measures that will be used to monitor performance. Remediation plans are monitored at least every 6 months. If such remediation actions do not have the intended effect, a revised strategy is implemented and monitored	summaries for some measures that referenced possible systemic remediation. In many instances, though, these did not include the specific strategy to be employed or define measures that would be used to monitor performance. The performance measures delegated to DMAS did generally note the applicable data source as the Quality Management Review (QMR), but the data definitions and data collection methodologies were not sufficient to ensure data reliability. Based on the findings for CI 36.01 and CI 38.01 below, for those measures for which DBHDS provided performance data, DBHDS had not yet determined that the data were valid and	was not a corresponding analysis for common factors, and a repeated form of remediation was to note that the performance measures "should be added as a reminder in notices to providers and included as an agenda item for the PRT." While a systemic focus was not often evidenced in the quarterly proceedings, the SFY 20 EOY Report provided summaries for some measures that referenced possible systemic remediation. In many instances, though, these did not include the specific strategy to be employed or define measures that would be used to monitor performance. In addition, as described for CI 35.07 below, this report covered a period from 7/1/19 through 6/30/20, so it was impractical to use the information for any comparative purposes to current year activities. Also for this review, while the performance measures delegated to DMAS did generally note the applicable data source as the Quality Management Review (QMR), as reported previously, the data definitions and data collection methodologies were not sufficient to ensure data reliability. Based on the findings for CI 36.01 and CI 38.01 below, for those measures for which DBHDS provided performance data, DBHDS had not yet determined that the data were valid and reliable and, therefore, may not be used for compliance reporting.	

Compliance Indicator	Facts	Analysis	Conclusion
	reliable and, therefore, may not be used for compliance reporting.		
35.06: DMAS provides administrative oversight for the DD Waivers in compliance with its CMS-approved waiver plans, coordinates reporting to CMS, and conducts financial auditing consistent with the methods, scope and frequency of audits approved by CMS.	*12VAC30-10-10* was current and indicated that DMAS is the single state agency designated to administer or supervise the administration of the Medicaid program under Title XIX of the Social Security Act. DMAS did not implement sufficient discovery activities to ensure the Commonwealth collected data to accurately measure performance or identify and implement any needed remediation, as it related to CI 49.02, CI 49.03 and CI 49.04. DBHDS did not submit evidence requested in the study proposal that DMAS conducted financial	At the time of the 17th Period review, this study described the structure of administrative oversight for the Commonwealth's DD waivers: • 12VAC30-120-1005(c) establishes DMAS as the single state agency authority pursuant to 42 CFR 431.10. It also establishes DBHDS as responsible for the daily administrative supervision of the DD waivers in accordance with the interagency agreement between DMAS and DBHDS. • 12VAC30-120-990(A) authorizes DMAS to perform quality management reviews for the purpose of assuring high quality of service delivery for individuals enrolled in the Commonwealth's waivers. • The approved waiver applications identify DMAS as the agency responsible for all required reporting requirements set out in the waiver. • DMAS conducts onsite and desk audit quality management reviews (QMRs) and contractor evaluations. Information collected through the DMAS QMR process is the source for much of the data that is aggregated and reported for each of the performance measures. For this review, it appeared these citations and designation of responsibilities remained largely current and correct. Based on a search of the current Virginia Administrative Code (accessed on 11/4/21 at https://law.lis.virginia.gov/admincode/title12/agency30/chapter120/section1005/), *12VAC30-120-1005* had been repealed. However, *12VAC30-10-10* was current and indicated that DMAS is the single state agency designated to administer or supervise the administration of the Medicaid program under Title XIX of the Social Security Act. However, this study could not confirm that DMAS fulfilled its responsibilities for two requirements for administrative oversight. Of note, the 17th Period study found this CI to be met, but that review did not include an in-depth examination of DMAS oversight of provider staff competencies. In addition, for this review, DBHDS did not provide all of the requested documentation to evidence compliance.	17th Met 19th Not Met

Compliance Indicator	Facts	Analysis	Conclusion
	auditing consistent with the methods, scope and frequency of audits approved by CMS	• As described below, this study found that DMAS did not implement sufficient discovery activities to ensure the Commonwealth collected data to accurately measure performance or identify and implement any needed remediation, as it related to CI 49.02 (i.e., requiring DSPs and DSP Supervisors, including contracted staff, providing direct services to meet the training and core competency requirements contained in DMAS regulation 12VAC30-122-180, including demonstration of competencies specific to health and safety within 180 days of hire), CI 49.03 (i.e., requiring DSPs and DSP Supervisors who have not yet completed training and competency requirements per the regulation to be accompanied and overseen by other qualified staff for the provision of any direct services), and CI 49.04 (i.e., requiring that at least 95% of DSPs and their supervisors receive training and competency testing). • DBHDS did not submit evidence requested in the study proposal that DMAS conducted financial auditing consistent with the methods, scope and frequency of audits approved by CMS and, based on interview, the DBHDS staff responsible for coordination of the QRT did not have knowledge of any financial auditing.	
35.07: The DMAS-DBHDS Quality Review Team will provide an annual report on the status of the performance measures included in the DD HCBS Waivers Quality improvement Strategy with recommendations to the DBHDS Quality Improvement Committee. The report will be available on the DBHDS website for CSBs' Quality Improvement committees to review. Documentation	On 9/29/21, DBHDS provided a final EOY report for SFY20 (i.e., for the period (7/1/19 through 6/30/20), noting that it was effective as of 9/27/21. Based on documentation provided for the 17th Period review, the previous EOY Report was published in May 2020. This did not meet the standard for being completed on an annual basis.	For the 17th Period review, the QRT's most recent approved End of Year (EOY) Report covered the period from 07/01/2018- 06/30/2019. Based on documentation provided for the 17th Period review, the previous EOY Report was published in May 2020. For this review, on 9/29/21, DBHDS provided a final EOY report for SFY20 (i.e., for the period 7/1/19 through 6/30/20), noting that it was effective as of 9/27/21. This did not meet the standard for being completed on an annual basis. For this review, DBHDS provided a document entitled *QRT Process for Notice and Review of the QRT EOY Report.* According to the document, by April 1st of each year, the Quality Review Team (QRT) End of Year (EOY) report from the prior year will be finalized with review and input from the QRT team and all QRT data SME's (QMR, Licensing, Human Rights, MRC.) The completed document would then be forwarded to the DOJ Team at DBHDS for an internal quality review to be completed by April 15th. The final EOY report would be posted on the DBHDS website by May 1st for a sixty day public comment period. E-mail notice about the availability of the report would be distributed via the DBHDS Provider listserv. Data highlights from the QRT EOY report were also to be shared by DBHDS at the Spring DS Council meeting by	17th Not Met 19th Not Met

Compliance Indicator	Facts	Analysis	Conclusion
of these reviews and resultant CSB-specific quality improvement activities will be reported to DBHDS. The above measures are reviewed at local level including by Community Service Boards (CSB) at least annually.	Based on the DOJ *Settlement Agreement – Process Document* submitted for review, the finalized QRT End of Year (EOY) Report is submitted to CSBs for review using a targeted Survey Monkey questionnaire. Based on interview with the QRT Manager, for the previous EOY Report, DBHDS received responses to the survey from 27 of 39 CSBs. The DOJ Settlement Agreement - Process Document did not specify any action DBHDS would take for non-compliance. Of note, this review process did not require documentation to show that the CSB Boards (e.g., rather than simply CSB staff) reviewed the	DBHDS. DBHDS would then compile public comment from both private providers and CSB's, to capture CSB and provider-specific remediation activities aimed at improving compliance with waiver assurances and soliciting general feedback and recommendations on the DD quality oversight process. Comments would be analyzed for application to relevant DBHDS quality improvement activities and were to be shared during the CRC/QMR Quarterly Meeting and the QRT Quarterly meeting for identification of actionable areas and resolution of issues/challenges identified. A formal response to all comments was to be developed with input from both reviews. It was unclear why it would take nine months to complete a draft EOY report for a given FY, when the QRT was completing ongoing quarterly updates. For example, based on the review schedule described in the process document and outlined in CI 35.05 above, the QRT would have completed all four quarter reviews for an SFY by 9/30, just three months after the end of the SFY. However, based on this schedule, the draft EOY Report for that FY would not be made public until 4/1 of the following year. The result of this scheduling would mean that draft report performance measure data would not be available to providers and CSBs until nearly the end of the following SFY, with the final report coming sometime after the conclusion of the following SFY. For example, for this review, on 10/19/21 (i.e., during the second quarter of SFY22), the last publicly posted report was for SFY19 (i.e., reporting performance data for the period 7/1/18 through 6/30/19.) As noted above, on 9/29/21, DBHDS did provide a final EOY report for SFY20 (i.e., for the period (7/1/19 through 6/30/20), noting that it was effective as of 9/27/21. However, it had not yet been posted publicly at that time. Reports with data that are more than 15 months old are not adequate or useful for CSB quality improvement committees to establish CSB-specific quality improvement activities. The remaining requirements for CI 35.07 focus on CSB review of QRT EOY reports, at least annually. Based on the aforementioned *DOJ Settlement Agreement - Process Document*, the finalized End of Year (EOY) Report is submitted to CSBs for review using a targeted *Survey Monkey* questionnaire. The process document states that the purpose of the questionnaire is to assess whether or not a CSB agrees with the reasons for noncompliance of a performance measure, collect data on standard and innovative remediation activities conducted by CSBs, and gather feedback on the overall QRT CSB review process. The questionnaire is designed to capture feedback on overall statewide provider compliance within a particular performance measure to capture	

Compliance Indicator	Facts	Analysis	Conclusion
	performance measures. Based on the findings for CI 36.01 and CI 38.01 below, for those measures for which DBHDS provided performance data, DBHDS had not yet determined that the data were valid and reliable and, therefore, may not be used for compliance reporting.	perceptions and/or any individual perspective on ways to improve compliance. CSBs are not expected to provide feedback on performance areas that are within the range of compliance, though there is an opportunity to do so in the questionnaire. Of note, this process did not require documentation to show that the CSB Boards (e.g., rather than simply CSB staff) reviewed the performance measures. Based on interview with the QRT Manager, for the previous EOY Report, DBHDS received responses to the survey from 27 of 39 CSBs. The *DOJ Settlement Agreement - Process Document* did not specify any action DBHDS would take for non-compliance. It was also not clear how the missing feedback might skew the overall understanding of CSB quality improvement activities. In addition to issues with timeliness of reporting and incomplete evidence that all CSB Boards reviewed the performance measures on an annual basis, based on the findings for CI 36.01 and CI 38.01 below, for those measures for which DBHDS provided performance data, DBHDS had not yet determined that the data were valid and reliable and, therefore, may not be used for compliance reporting. Data that have not been determined reliable and valid do not provide an effective basis for determining quality improvement strategies and recommendations.	
35.08: The Commonwealth ensures that at least 86% of individuals who are assigned a waiver slot are enrolled in a service within 5 months, per regulations.	DBHDS did not provide any documentation to show that the Commonwealth ensures that at least 86% of individuals who are assigned a waiver slot are enrolled in a service within 5 months, per regulations. DBHDS did not provide evidence of	At the time of the 17th Period, the study found that data for this indicator was reported as a Key Performance Measure for DBHDS. The *Provider Data Summary* dated 07/23/20 indicated performance at 95.1%. Also at the time of the 17th period review, DBHDS staff reported that verification of the accuracy, completeness, and reliability of the data for this measure was outlined in standard operating procedures. However, DBHDS did not provide a detailed methodology for collection of valid and reliable data. For this review, DBHDS did not provide any data to show that the Commonwealth ensures that at least 86% of individuals who are assigned a waiver slot are enrolled in a service within 5 months. • As described with regard to CI , as of 10/8/21, a current semi-annual Provider Data Summary was not available at either the Library Website or the DBHDS Website. The most recent version available was on the Provider Development	17th Not Met 19th Not Met

Compliance Indicator	Facts	Analysis	Conclusion
	data collection for this measure, either in a current *Provider Data Summary* or the *QRT EOY Report.* DBHDS did not provide a data collection methodology to ensure valid and reliable data for this measure.	webpage, which provided a link to *Provider Data Summary Semi-Annual Report State Fiscal Year 2020-2021*, covering the period between May 1, 2020 to October 31, 2020. It did not include reporting on this measure. DBHDS did not otherwise submit a current *Provider Data Summary Semi-Annual Report* for this review. • The *QRT EOY Report* did not address this measure. For this review, DBHDS submitted PMI methodology templates for 37 measures, but did not include a data collection methodology for this measure to ensure valid and reliable data.	

V.D.2 Analysis of 19th Review Period Findings

Section V.D.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.**

Compliance Indicator	Facts	Analysis	Conclusion
36.01: DBHDS develops a Data Quality Monitoring Plan to ensure that it is collecting and analyzing consistent reliable data. Under the Data Quality	DBHDS issued updates to the *Data Quality Monitoring Plan* in April 2021 and June 2021. These included the *Data*	At the time of the 17th Period review, The Office of Data Quality and Visualization (DQV) had issued a *Data Quality Monitoring Plan*, dated Fall 2019, a number of ensuing associated reports on data quality and reliability (the *Data Quality Plan Source Systems Assessments: Findings and Recommendations December 2019* and *Data Quality Plan Source Systems Assessments: Findings and Recommendations from an agency perspective, January 2020*) and an update to the QIC in September 2020 (i.e., *DBHDS Data Quality Monitoring Plan: Major*	17th Met 19th Not Met

Compliance Indicator	Facts	Analysis	Conclusion
Monitoring Plan, DBHDS assesses data quality, including the validity and reliability of data and makes recommendations to the Commissioner on how data quality issues may be remediated. Data sources will not be used for compliance reporting until they have been found to be valid and reliable. This evaluation occurs at least annually and includes a review of, at minimum, data validation processes, data origination, and data uniqueness.	*Quality Monitoring Plan: Annual Update Process*, dated April 2021; the *Data Quality Monitoring Plan Source System Annual Update*, dated June 2021; and, the *Data Quality Monitoring Plan: Reassessment with Actionable Recommendations*, also dated June 2021. DBHDS issued the previous *Data Quality Monitoring Plan* in the Fall of 2019. The *Data Quality Monitoring Plan Source System Annual Update* stated that the recommendations from the original version of the *Data Quality Monitoring Plan,* dated Fall 2019, and the accompanying source systems assessments had not yet been addressed in a comprehensive manner. Further, it concluded that additional efforts are needed to sufficiently	*Findings and Recommendations from the First Year of Implementation*.) Overall, based on the documentation reviewed and interviews with DBHDS staff, the data sources had not yet been found to produce reliable data and so could not yet be used for compliance reporting. For this review, DBHDS acknowledged that had not yet addressed the recommendations from the original version in a comprehensive manner, but had issued several additional documents as updates to the *Data Quality Monitoring Plan*. These included the *Data Quality Monitoring Plan: Annual Update Process*, dated April 2021; the *Data Quality Monitoring Plan Source System Annual Update*, dated June 2021; and, the *Data Quality Monitoring Plan: Reassessment with Actionable Recommendations*, also dated June 2021. A summary of each is provided below. However, of note, due to the significant delay by DBHDS in providing these documents for review, this study could not complete any independent verification of the implementation of any assertions or processes contained in the documents. • *Data Quality Monitoring Plan: Annual Update Process:* This document described a methodology by which the DBHDS Office of DQV planned to complete an annual update for each of the data sources systems as identified in the 2019 and 2020 data quality monitoring documents referenced above. Based on this document, the annual update process will include interviews with Subject Matter Experts (SMEs) and IT Project Management Office, as well as review of Weekly Status Report Documents and e-mail correspondence between the Office of DQV and SMEs. The Data Quality and Administrative Specialist will review and update all documents, templates, and data collection forms, and access information about possible updates to a source system from the IT Weekly Project Management Office (PMO) Status Update Documents. These documents track progress that IT has made on the various updates and requests that have been placed to the department over time. As the Office of DQV gathers information from each of the sources outlined above, the Data Quality and Administrative Specialist will compile all of the information into an Annual Update Data Collection Workbook. The document notes that the resulting update will be neither a reassessment nor an independent verification and validation. Instead, a complete reassessment will happen every 3-5 years starting with the sources systems in SFY 2022. This latter process is described in the	

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<tr><th>Compliance Indicator</th><th>Facts</th><th>Analysis</th><th>Conclusion</th></tr>
<tr><td></td><td>address data quality as outlined in the original report.

The Data Quality Monitoring Plan Source System Annual Update described some steps DBHDS staff had taken since issuance of the original source system assessments to improve data quality in eight of the previously studied source systems, but did not assert that any of the source systems produced valid and reliable data. Due to the significant delay by DBHDS in providing these documents for review, this study could not complete any independent verification of implementation of the described improvements.

Therefore, the data from these source systems cannot yet be</td><td>Data Quality Monitoring Plan: Reassessment with Actionable Recommendations further below.

• Data Quality Monitoring Plan Source System Annual Update: This DBHDS document is the first annual update produced using the methodology described in the preceding paragraph. In addition to a chart of source systems, as replicated below, it included a narrative description of the improvements DBHDS indicated staff had made to eight source system in the following categories: Key Documentation, Data Validation Controls, User Interface, Business Ownership, and Maturity (i.e., consistent with the categories in the original source system assessments from 2019.) The specific improvement listed in this report are outlined further with regard to CI 38.01 below.

<table>
<tr><th>Source System</th><th>Categories of improvement</th><th>Replacement pending</th></tr>
<tr><td>Avatar</td><td>Data Validation</td><td>No</td></tr>
<tr><td>Children in Nursing FacilitiesSpreadsheet</td><td>None</td><td>Yes</td></tr>
<tr><td>CHRIS-OHR/SIR</td><td>Key Documentation, Data Validation, UserInterface, Business Ownership</td><td>Yes</td></tr>
<tr><td>Employment Spreadsheet</td><td>Key Documentation, Data Validation,Business Ownership</td><td>No</td></tr>
<tr><td>IFSP – Individual and FamilySupport Program</td><td>None</td><td>Yes</td></tr>
<tr><td>eMRF – Electronic Mortality Review Form</td><td>Key Documentation, Data Validation, UserInterface, Business Ownership, Maturity</td><td>Yes</td></tr>
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</td><td></td></tr>
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<table>
<tr><th>Compliance Indicator</th><th>Facts</th><th>Analysis</th><th>Conclusion</th></tr>
<tr><td></td><td>used for compliance reporting.

In addition, in many instance, the Office of DQV had not completed an annual assessment of the PMI data collection methodologies.</td><td>
<table>
<tr><td>OLIS – Office of Licensing Information System</td><td>Key Documentation, Business Ownership</td><td>Yes</td></tr>
<tr><td>PAIRS - Protection and Advocacy Incident Reporting System</td><td>None</td><td>No</td></tr>
<tr><td>REACH - Regional Educational Assessment Crisis Habilitation</td><td>Key Documentation, Data Validation</td><td>Yes</td></tr>
<tr><td>RST - Regional Support Team</td><td>Key Documentation, Data Validation,Business Ownership</td><td>Yes</td></tr>
<tr><td>WaMS - Waiver Management System</td><td>Key Documentation, User Interface</td><td>No</td></tr>
</table>

The document further noted that, while the original recommendations presented by the first Data Quality Monitoring Plan reports have not been implemented, some steps have been taken to improve data quality to a variable extent. Further, it stated that while these improvements and plans for improvements by Business Owners are steps in the right direction, additional efforts were needed to sufficiently address data quality as outlined in the original Data Quality Monitoring Plan report. In other words, the DBHDS did not assert that any of the previously reviewed source systems have been assessed after it identified obstacles to providing reliable and valid data and that its Office of DQV has not determined that these source systems currently produced data that could be considered valid and reliable and used for compliance reporting.
</td><td></td></tr>
</table>

Compliance Indicator	Facts	Analysis	Conclusion
		• *Data Quality Monitoring Plan: Reassessment with Actionable Recommendations:* The *Data Quality Monitoring Plan Source System Annual Update* described above also set the stage for the third document discussed in this section, in stating the following: "At the request of the DOJ SA Steering Committee, in order for DBHDS to address and act upon the recommendations outlined in the SFY2020 Data Quality Monitoring Plan, DQV has agreed to conduct another assessment to develop actionable recommendations in SFY 2022. This will include the execution of an entirely new methodology by which DQV will shadow personnel that enter the data, obtain access to the appropriate system environment to test the data, and conduct interviews with numerous personnel to obtain the most holistic perspective of each system. Through this in-depth process, DQV will identify major threats to data validity and reliability within each source system and develop a list of up to twelve actionable recommendations that must be successfully addressed by IT or the Business Owner in order for the Chief Clinical Officer to affirm the validity and reliability of the system. Concurrently, IT must collaborate with the respective business areas to address findings from the initial DQMP source system and data warehouse assessments." Accordingly, the *Data Quality Monitoring Plan: Reassessment with Actionable Recommendations* stated the Office of DQV would reassess systems on a rolling basis, focusing on one at a time until each source system included in the original *Data Quality Monitoring Plan* has been completed. As an output of this process, the Office of DQV will identify up to twelve actionable recommendations for each system, that, if completed, will result in the greatest improvement to data validity and reliability. The document also outlined a logical set of ten steps the Office of DQV will undertake efforts to fulfill the purpose described above, including the development of 12 actionable recommendations for each source system. These include: Step 1: DQV Consultation and Question Development Step 2: Review Training Materials Step 3: Subject Matter Expert Interviews Step 4: Key Stakeholder Interviews Step 5: Shadowing Step 6: Source System Table Analysis	

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<tr><th>Compliance Indicator</th><th>Facts</th><th>Analysis</th><th>Conclusion</th></tr>
<tr><td></td><td></td><td>
Step 7: Review and Synthesis
Step 8: Peer Review
Step 9: Presentation of Actionable Recommendations
Step 10: Follow-up

Based on interview with DBHDS staff, this process is just beginning and the first source system for focus will be WaMS.

In addition to the continuing deficiencies related to the data source systems as described above, in many instances, the Office of DQV had not completed an annual assessment of the PMI data collection methodologies and/or had identified threats to validity and reliability that had not yet been addressed. In addition, when DBHDS Data Stewards did make modification to the data collection methodologies, the Office of DQV had not consistently reviewed those to ensure the modifications were sufficient to address the identified threats. The charts below list the SFY 21 measures by domain and identify the data source system(s) for each. Following each domain chart is a summary of deficiencies with regard to ensuring data validity and reliability, including, but not limited to recency of review by the Office of DQV.

<table>
<tr><th colspan="2">Safety and Freedom from Harm</th></tr>
<tr><th>Measure</th><th>Data Source(s)</th></tr>
<tr><td>1. HSWB KPA: For 95% of individual service recipients, seclusion or restraints are only utilized after a hierarchy of less restrictive interventions are tried (apart from crises where necessary to protect from an immediate risk to physical safety), and as outlined in human rights committee-approved plans</td><td>CHRIS-OHR
WaMS</td></tr>
<tr><td>2. RMRC: State policies and procedures for the use or prohibition of restrictive interventions (including seclusion) are followed.</td><td>CHRIS-OHR
WaMS</td></tr>
<tr><td>3. RMRC: State policies and procedures for the use or prohibition of restrictive interventions (including restraint) are followed.</td><td>Not Stated;
No
PMI Measure
Template
Submitted</td></tr>
</table>
</td><td></td></tr>
</table>

Compliance Indicator	Facts	Analysis		Conclusion
		4. RMRC: Licensed providers meet the regulatory requirements for quality improvement programs.	OLIS DW-0097	
		5. RMRC: Individuals are free from harm, as reflected in the rates of serious incidents that are related to risks which are prevalent in individuals with developmental disabilities; including: 1.aspirationpneumonia 2.bowel obstruction 3.sepsis 4.decubitus ulcer 5.fall or trip 6.dehydration 7.seizures 8.choking 9.urinary tract infection 10.self-injury 11. sexual assault 12. suicide attempt	CHRIS-SIR WaMS	
		6. RMRC: Corrective actions for substantiated cases of ANE are verified by DBHDS as being implemented (DBHDS verifies that providers' corrective actions for substantiated case of ANE are implemented)	CHRIS-SIR	
		7. RMRC: Critical incidents are reported to OL within the required timeframes.	CHRIS-SIR	
		8. RMRC: Licensed DD provider that administer medications are NOT cited for failure to review medication errors at least quarterly.	Not Stated: No PMI Measure Template Submitted	
		9. RMRC: Provider investigations of abuse and neglect allegations are conducted in accordance with regulations of the Office of Human Rights.	CHRIS-OHR	
		10. RMRC: The number of licensed providers, by service, that were determined to be compliant with each of the quality improvement regulations (620) during an unannounced annual inspection; reported separately.	OLIS	

Compliance Indicator	Facts	Analysis	Conclusion
		• For the measure related to utilization of seclusion or restraints only after a hierarchy of less restrictive interventions are tried, the PMI template provided for review was incomplete and appeared to be in draft form only. The Office of DQV had not completed a formal review. • For the measure related to state policies and procedures for the use or prohibition of restrictive interventions (including seclusion), the Office of DQV reviewed this measure in February 2021 and found concerns, including a lack of reliance on the discrete categorical fields within the source system to return valid results, suggesting a need for the systemic issues to be addressed related to the CHRIS source system (i.e., as based on recommendations from the *Data Quality Monitoring Plan*.) • DBHDS did not submit a PMI template for the measure related to state policies and procedure regarding restraints. • DBHDS did not submit a PMI template for the measure related to provider medication administration. • For two other measures (i.e., rates of risk conditions and providers meeting the regulatory requirements for quality improvement programs), the last documented reviews by the Office of DQV occurred in September 2020.	

Physical, Mental, and Behavioral Health and Well-being	
Measure	**Data Source(s)**
1. CMSC: The case manager assesses whether the person's status or needs for services and supports have changed and the plan has been modified as needed.	Support Coordination Quality Review (SCQR)
2. CMSC: Individual support plans are assessed to determine that they are implemented appropriately.	SQRC
3. HSWB KPA: Individuals on the DD waivers will have a documented annual1physical exam date.	WaMS

Compliance Indicator	Facts	Analysis	Conclusion

4. HSWB KPA: Individuals on the DD waivers will have an actual annual1physical exam date.	WaMS
5. MRC: Unexpected deaths where the cause of death, or a factor in the death, was potentially preventable and some intervention to remediate was taken.	The Action Tracking Log

- For both measures related to ISPs, the Office of DQV had not completed an annual review to ensure the validity and reliability of the data since June 2020. At that time, the review indicated threats to reliability and validity. On 2/25/21, the Data Steward indicated he had worked with the Office of DQV to create a separate report with raw data counts on 2/22/21 for all SCQR elements. However, there was no evidence provided of an Office of DQV review of the modified process to ensure sufficiency.
- For both measures related to annual physical exams, the Office of DQV had not completed an annual review to ensure the validity and reliability of the data since June 2020 or one and July 2020 for the other. At that time, for both measures, the review indicated threats to reliability and validity and indicated that data provenance would be developed detailing the steps that must be taken to export the requisite data from WaMS and be appended to this document once available. DBHDS did not submit an updated provenance document.

Avoiding Crises	
Measure	**Data Source(s)**
1. Individuals who are admitted into REACH mobile crisis supports will have a CEPP completed within 15 days of their admission into the service	REACH data store

- Based on the PMI template provided for review, the Office of DQV staff reviewed it on 6/29/21 and did not identify any potential threats to PMI validity or reliability at that time. However, as described with regard to CI 38.01 below, despite some improvements DBHDS reported for this review, the

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REACH data source system had not yet been verified to produce valid and reliable data. Therefore, the data cannot be used to confirm compliance.
<table>
<tr><th colspan="2">Stability</th></tr>
<tr><th>Measure</th><th>Data Source(s)</th></tr>
<tr><td>1. CII KPA: Individuals have stability in independent housing</td><td>Housing Resource Referral Spreadsheet</td></tr>
<tr><td>2. CII KPA: Individuals on the DD waivers and waitlist are working in ISE or GSE for 12months or longer.</td><td>ESOs/DARS data reports and WaMS</td></tr>
<tr><td>3. RMRC: Individuals on the DD waivers and known to REACH who are admitted to CTH facilities will have a community residence identified within 30 days of admission.</td><td>REACH Data Store and “No Disposition Tracker.”</td></tr>
</table>

The Office of DQV last reviewed the measure for stability in independent housing in September 2020.
For the measure for individuals working 12 months or longer, the Office of DQV last reviewed this measure in August 2021, which was current, but identified potential threats to PMI validity and reliability. Based on review of the PMI template submitted, the Data Steward had not developed a mitigating strategy to address the measure. A comment noted that a DBHDS had shared a draft process on 8/9/21, but it was not included.
For the measure related to REACH referrals, as described with regard to CI 38.01 below, despite some improvements DBHDS reported for this review, the REACH data source system had not yet been verified to produce valid and reliable data.

<table>
<tr><th colspan="2">Choice and Self-determination</th></tr>
<tr><th>Measure</th><th>Data Source(s)</th></tr>
<tr><td>1. CMSC: Individuals are given choice among providers, including choice of support coordinator, at least annually</td><td>SCQR</td></tr>
</table>
</td><td></td></tr>
</table>

Compliance Indicator	Facts	Analysis	Conclusion

2. CMSC: Individuals participate in an annual discussion with their Support Coordinator about relationships and interactions with people (other than paid program staff).	SCQR
3. CII KPA: At least 75% of people receiving services who do not live in the family home/their authorized representatives chose or had some input in choosing where they live	WaMS

- For the measure related to choice among providers, the Office of DQV last reviewed this measure in June 2020 and identified potential threats to PMI validity and reliability, including a recommendation to transition data collection from the SCQR to WaMS. There had been no annual review or update with regard to the use of WaMS.
- For the measure related to discussing relationships, the Office of DQV last reviewed this measure in June 2020 and identified potential threats to PMI validity and reliability. The Data Steward added content about the data collection methodology on 2/9/21, but there was no evidence the Office of DQV had reviewed these changes.
- For the measure regarding choice of living arrangement, there was no evidence that the Office of DQV had completed a review of data validity and reliability.

Community Inclusion	
Measure	**Data Source(s)**
1. CII KPA: Individuals with an active waiver are involved in their community without barriers.	WaMS
2. CII KPA: Individuals with an active waiver are involved in their community through the most integrated support	WaMS
3. CII KPA: Individuals live in independent housing	DDS Housing Outcomes Table

Compliance Indicator	Facts	Analysis	Conclusion

	excel spreadsheet and WaMS.
4. CMSC: Individuals aged 14-17 who are receiving waiver services will have a discussion about their interest in employment and what they are working on while at home and in school toward obtaining employment upon graduation, and how the waiver services can support their readiness for work, included in their ISP.	WaMS ISP Data Report.

- For the CII KPA measures for community involvement (i.e., without barriers and through the most integrated support), the Office of DQV last reviewed them in June 2020 and did not identify any threats to PMI validity or reliability at that time. However, based on the findings for CI 36.01 and CI 38.01, the Office of DQV had not yet determined that the applicable data source system (i.e., WaMS) produced valid and reliable data.
- The Office of DQV last reviewed the measure of individuals living in independent housing in January 2021 and did not identify any potential threats to PMI validity or reliability at that time. However, the PMI narrative identified limitations that could impact data reliability, including, but not limited to, that DBHDS was not capturing all individuals who are in independent housing who did not go through the voucher program. No update was provided to address the limitations.
- For the measure related to the teen employment discussion, the PMI data collection methodology was still in development, so the Office of DQV had not yet had the opportunity to assess it.

Access to Services	
Measure	**Data Source(s)**
1. CMSC: Adults (age 18-64) with a DD Waiver receiving case management services from the CSB whose ISP, developed or updated at the annual ISP meeting, contains employment outcomes, including outcomes that address barriers to employment.	CCS3/WaMS

Compliance Indicator	Facts	Analysis	Conclusion

2. CMSC: Regional Support Team referrals are timely for individuals considering a move into group homes of 5 or more beds	RST Spreadsheet/ WaMS
3. CMSC: Regional Support Team (RST) non-emergency referrals are made in sufficient time for the RSTs to meet and attempt to resolve identified barriers.	RST Spreadsheet/ WaMS
4. CMSC: Individuals receiving case management services from the CSB whose ISP, developed or updated at the annual ISP meeting, contained Medicaid DD Waiver Community Engagement/or Community Coaching services goals	WaMS
5. PCC KPA: Data continues to indicate an annual 2% increase in the overall DD waiver population receiving services in the most integrated settings.	WaMS
6. PCC KPA: Data continues to indicate that at least 90% of individuals new to the waivers, including for individuals with a "supports need level" of 6 or 7, since FY16 are receiving services in the most integrated setting.	WaMS
7. PCC KPA: The Data Summary indicates an increase in services available by locality over time.	WaMS
8. PCC KPA: Assess if transportation provided by waiver service providers (not to include NEMT) is being provided to facilitate individuals' participation in community activities and Medicaid services per their ISPs.	DBHDS Quality Service Review (QSR)

- For the RST referral measures, the Office of DQV reviewed one (i.e., five bed referrals) in June 2020 and the other (i.e., non-emergency referrals) in March 2021. In both instances, the Office of DQV identified potential threats to validity and reliability related to the manual data tracking and reporting in the RST Spreadsheet. On 3/1/21, both PMI documents indicated that to remediate the manual processes around data cleaning and reporting, the RST transition to integrate into the WaMS system had been priced, but the status of

<table>
<tr><th>Compliance Indicator</th><th>Facts</th><th>Analysis</th><th>Conclusion</th></tr>
<tr><td></td><td></td><td>
that transition was unknown. At the time of this review, approximately seven months later, DBHDS did not provide any update.

In February 2021 and again on June 9, 2021, Office of DQV staff assisted the Data Steward with developing the initial draft of the measure based on the Provider Data Summary. DQV staff noted a potential threat to PMI validity and reliability at that time because the PMI documentation lacked any calculation steps. There had been no subsequent updates.
The documentation for three measures (i.e., regarding transportation, a two percent increase for I/DD waiver population receiving services in the most integrated settings and 90% of new waiver participants receiving integrated services) indicated that the Office of DQV had completed an assessment of data reliability and validity in the past 12 months and did not identify any potential threats. However, they did not provide documentation to show the data source systems produced valid and reliable data.

<table>
<tr><th colspan="2">Provider Capacity</th></tr>
<tr><th>Measure</th><th>Data Source(s)</th></tr>
<tr><td>1. PCC KPA: Provider investigations of abuse and neglect allegations are conducted in accordance with regulations of the Office of Human Rights.</td><td>CHRIS/OHR</td></tr>
<tr><td>2. PCC KPA: People with DD waiver are supported by trained, competent Direct Support Professionals (DSPs).</td><td>DBHDS/DMAS QRT quarterly report.</td></tr>
<tr><td>3. CMSC: Individuals receiving Developmental Disability case management services identified as meeting ECM criteria will receive face to face visits every other month in their residence.</td><td>CCS3</td></tr>
<tr><td>4. CMSC: Individuals meeting ECM criteria receive F2F visits every other month</td><td>CCS3</td></tr>
</table>

For the PCC KPA measure related to competent DSPs, DQV assisted the Measure Steward with the initial draft of the measure in February 2021. DQV staff assisted the Data Steward with finalizing the PMI on June 9, 2021, and did not identify any potential threats to PMI validity and reliability at that time.

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Compliance Indicator	Facts	Analysis	Conclusion
		However, PMI template for this measure did not actually describe the steps of the data collection methodology. As described, the study's findings with regard to CI 49.01 through CI 49.03, the Commonwealth was not yet collecting valid and reliable data for this measure. • For the two measures related to enhanced case management (ECM), the respective PMI templates did not document a review by the Office of DQV. However, based on previous findings by the Office of DQV, CCS 3 was not a source that produced valid and reliable data.	
36.02: DBHDS analyzes the data collected under V.D.3.a-h to identify trends, patterns, and strengths at the individual, service delivery, and system level in accordance with its Quality Improvement Plan. The data is used to identify opportunities for improvement, track the efficacy of interventions, and enhance outreach and information.	For the 19th Period review, minutes from the QIC, KPA Workgroups, RMRC, CMSC and MRC included analyses of data collected under V.D.3.a-h. Based on their analyses the QIC, KPA Workgroups, and committees identified opportunities for improvement, tracked the efficacy of interventions, and enhance outreach and information. However, as described above for CI 36.01 and for CI 36.05 and CI 38.01 below with regard to	Based on review of documentation submitted, including meeting minutes from the QIC, RMRC, MRC, CMSC and the KPA Workgroups, DBHDS was using available surveillance data collected pursuant to V.D.3.a-h to complete analyses with regard to trends and patterns. Those minutes also showed that, based on their analyses, the KPA Workgroups, and other QIC subcommittees identified opportunities for improvement, tracked the efficacy of interventions, and enhanced outreach and information. In addition to the opportunities for enhanced outreach and information described with regard to CI 36.07 below, each of the workgroups and subcommittees identified, implemented and tracked the efficacy of Quality Improvement Initiatives (QIIs), based on data they reviewed from PMIs and other surveillance data. Many of these are also referenced with regard to CI 36.07 below. However, as described above for CI 36.01 and CI 38.01 below with regard to data quality for the source systems, DBHDS had not yet ensured the data used for analysis was reliable. Therefore, it cannot be used for the purpose of compliance reporting.	17th Not Met 19th Met*

Compliance Indicator	Facts	Analysis	Conclusion
	data quality, DBHDS had not yet ensured the data used for analysis was reliable. Therefore, it cannot be used for the purpose of compliance reporting.		
36.03 At least annually, DBHDS reviews data from the Quality Service Reviews and National Core Indicators related to the quality of services and individual level outcomes to identify potential service gaps or issues with the accessibility of services. Strategic improvement recommendations are identified by the Quality Improvement Committee (QIC) and implemented as approved by the DBHDS Commissioner.	For the 19th Period review, minutes from the QIC included at least an annual review of data from the Quality Service Reviews and National Core Indicators. Data reviewed was related to the quality of services and individual level outcomes to identify potential service gaps or issues with the accessibility of services. From the related data, the presentation identified improvement recommendations.	At the time of the 17th Period review, DBHDS' new QSR vendor was just wrapping up their initial set of reviews and no data were yet available for review. During this review period, DBHDS staff provided second round Quality Services Review data to the QIC for review. For the QIC meeting for 9/27/21, DBHDS provided a PowerPoint presentation entitled *2021 Quality Service Review Report to QIC*, dated September 2021. In addition to the presentation of data, it recommended opportunities for improvement in each of the three KPA domains. For the HSWB KPA domain, the presentation recommended opportunities for improvement to ensure that: • CSBs and providers review QAPI plan, improvement programs, risk and risk management programs, and seeking ongoing technical assistance from DBHDS to ensure compliance, QIP development and execution. • Protocols for physical and behavioral risks are documented, and that ISPs are revised to include outcomes and supports for individuals' risks of harm. For the CII KPA domain, the presentation recommended opportunities for improvement to ensure that: • CSBs consider retraining of support coordinators on expectations for documentation to be completed quarterly or every 90-days. • CSBs and providers have clear documentation and training of their backup plans and risk minimizing strategies for all areas of operation. • CSBs ensure support coordinator understanding of the expectation for documentation of activities and efforts made to address individual risk. CSBs	17th Not Met 19th Not Met

Compliance Indicator	Facts	Analysis	Conclusion
	Based on the 6/30/21 minutes provided for review, the QIC did not recommend any action steps. DBHDS did not submit the minutes for the 9/27/21, so it was unknown if the QIC made any recommendations or took any actions related to these improvement recommendations. In addition, based on the lack of DBHDS confirmation that the QSR produced valid and reliable data, the QSR data cannot be used for compliance reporting.	should provide additional clinical-based training to support coordinators that assists with identification of risks, needs, and change in status. For the PCC KPA domain, the presentation recommended opportunities for improvement to ensure that: • CSBs retrain the support coordinators on expectations for timely contacts, and/or implementation of audits to identify and address any process improvement needs. • CSBs and providers document how the support staff/sponsor home providers successfully complete and on an on-going bases receive competency-based training related to elements of the individuals support plan. DBHDS did not provide draft QIC minutes for the meeting held on 9/27/21, so it is unknown if the QIC acted on any of these second round recommendations. DBHDS staff did not provide any documentation to show whether they made any recommendations for improvements based on data from the first round. In any event, based on the lack of DBHDS confirmation that the QSR produced valid and reliable data, the QSR data cannot be used for compliance reporting. At the time of the 17th Period review, on 6/30/20, the QIC members reviewed two documents, the *In- Person Survey (IPS) State Report 2018-19* and a PowerPoint presentation entitled *2018-2019 National Core Indicators (NCI) Annual Report June 30, 2020.* Due to time constraints, members were provided with an email contact for a designated staff should they have any questions regarding the report. During this review period, DBHDS staff continued to provide National Core Indicators (NCI) data to the QIC for review on an annual basis. On 6/28/21, the QIC minutes reflected a presentation of NCI data, entitled *Using Virginia's NCI Data: National Core Indicators In-Person Survey*. Based on review of the presentation, it included data related to the quality of services and individual level outcomes including, for example, Social and Community Participation, Choice and Self-Determination, Support and Service Quality and Risk. The presentation also provided some examples of how the data might be used to identify potential service gaps or issues with the accessibility of services (e.g., examining disparities between black respondents compared to white.) Based on a review of the QIC minutes provided, the presenter noted that NCI can examine	

Compliance Indicator	Facts	Analysis	Conclusion
		disparity by race, rural/urban and states have the opportunity to expand questions or their sampling to further identify disparities. In addition, the presentation noted NCI data can be used in conjunction with other data sets to predict outcomes for individuals. The minutes indicated that the QIC did not make any recommendation for strategic improvements related to the NCI data at that time. DBHDS did not provide draft QIC minutes for the meeting held on 9/27/21, so it is unknown if the QIC had made any further recommendations.	
36.04: DBHDS quality committees and workgroups, including Mortality Review Committee, Risk Management Review Committee, Case Management Steering Committee, and Key Performance Area (KPA) workgroups, establish goals and monitor progress towards achievement through the creation of specific KPA Performance Measure Indicators (PMI). These PMIs are organized according to the domains, as outlined in the Settlement Agreement in V.D.3.a-h. PMIs are also categorized as either outcomes or outputs: a. Outcome PMIs focus on what individuals achieve as a result of services and supports they receive (e.g.,	DBHDS quality committees and workgroups created specific KPA Performance Measure Indicators (PMI) organized according to the domains, as outlined in the Settlement Agreement in V.D.3.a-h DBHDS categorized the PMIs as either outcomes or outputs. As described above for CI 36.01 and for CI 36.05 and CI 38.01 below with regard to data quality, DBHDS had not yet ensured the data used for analysis was reliable. Therefore, it cannot	At the time of the 17th period review, DBHDS had developed the DBHDS Quality Management Plan FY20, effective 9/13/19, which chartered three KPA workgroups, one for each domain, and charged them with the proposal and development of measures, which would be reviewed and approved by the QIC. DBHDS had also promulgated *Departmental Instruction 316 (QM) 20, Quality Improvement, Quality Assurance, and Risk Management for Individuals with Developmental Disabilities*. That document defined three broad categories aimed at addressing the availability, accessibility, and quality of services, those being Health, Safety and Well Being, Community Inclusion and Integration, and Provider Competency and Capacity. For this review, DBHDS provided an updated *Departmental Instruction 316 (QM) 20, Quality Improvement, Quality Assurance, and Risk Management for Individuals with Developmental Disabilities* (DI 316), dated 04/07/21. It described the QIC subcommittee and KPA workgroup functions in a manner that was consistent with the requirements of CI 36.04: • The RMRC shall provide ongoing monitoring of incident data, including serious incidents and allegations and substantiations of abuse, neglect, and exploitation; and analysis of individual, provider, and system level data to identify trends and patterns and make recommendations to promote health, safety, and well-being of individuals. As a subcommittee of the QIC, the RMRC identifies and addresses risks of harm; ensures the sufficiency, accessibility, and quality of services to meet individuals' needs in integrated settings; and collects and evaluates data to identify and respond to trends to ensure continuous quality improvement. The RMRC ensures that approved quality improvement initiatives are implemented and reported to the QIC. • The MRC shall focus on system-wide quality improvement by conducting mortality reviews of deaths of individuals of individuals with DD reported to DBHDS through its incident reporting system.	17th Not Met 19th Not Met

Compliance Indicator	Facts	Analysis	Conclusion
they are free from restraint, they are free from abuse, and they have jobs). B. Output PMIs focus on what a system provides or the products (e.g., ISPs that meet certain requirements, annual medical exams, timely and complete investigations of allegations of abuse).	be used for the purpose of compliance reporting.	• The CMSC oversees and coordinates various activities to strengthen the case management system and collaborates with the Provider Capacity and Competency Workgroup. The committee's overall goals are to: o Ensure and oversee the coordination of all internal and external quality improvement activities that affect both the transactional and transformational components of case management; o Identify strengths, weaknesses, and gaps in newly implemented products and processes; and o Make recommendations for system improvement. • The Health, Safety, and Well-being Workgroup is responsible for the collection and analysis of data as it relates to helping individuals achieve positive health outcomes, remain safe from harm, and avoid crises. The workgroup establishes goals and performance measures related to physical, mental, and behavioral health well-being. Data related to prevention strategies, wellness trends, and clinical outcomes are monitored. • The Community Inclusion and Integrated Settings Workgroup is charged with promoting stable service provision in the most integrated settings appropriate to each individual's needs and consistent with the individual's informed choice and ensuring full access and participation in community life. The workgroup establishes goals and performance measures to help ensure the most integrated settings appropriate to the individuals' needs, community stability, individual choice, self-determination, and community inclusion. • The Provider Capacity and Competency Workgroup is charged with improving availability of and access to services across the Commonwealth and facilitating provider training, competency, and quality service provision. The workgroup establishes goals and performance measures related to provider capacity, access to services, and provider competency. At the time of this review, DBHDS provided documentation indicating it currently had 16 measures for the Health, Safety and Well-being domain (i.e., ten for Safety and Freedom from Harm, five for Physical, Mental and Behavioral Health and one for Avoiding Crisis); ten outcome measures for Community Inclusion and Integration (i.e., three for Stability, three for Choice and Self-Determination and four for Community Inclusion); and, twelve measures for Provider Competency and Capacity (i.e., eight for	

Compliance Indicator	Facts	Analysis	Conclusion
		Access to Services and four for Provider Capacity). The tables for CI 36.01 show each of these measures, organized by domain. At the time of the 17th Period review, the study found that, while the Technical Guidance for Measure Development for use by DBHDS staff defined the terms "outcome" and "output" measures in a manner consistent with this indicator, it was not clear that DBHDS staff had applied the guidance in a manner that was also consistent with the compliance indicators. It appeared that DBHDS still sometimes staff incorrectly identified measures as outcomes when they were, in fact, output measures. Examples included "individuals receiving case management services from the CSB whose ISP, developed or updated at the annual ISP meeting, contained Medicaid DD Waiver Community Engagement/or Community Coaching services goals," and "individuals participate in a discussion with their Support Coordinator about relationships and interactions with people other than paid program staff." These measures reflected expectations for ISP requirements rather than outcomes for individuals (e.g., individuals are engaged and included in their communities or individuals have relationships with people in the community other than paid program staff.) The study previous recommended that DBHDS revisit the designation of measures as output vs. outcome, and For this review, the charts below summarize the information DBHDS submitted regarding the designation of type (i.e., outcome vs. output) for each measure, organized by domain. In most instances, it appeared DBHDS staff had applied a correct designation. However, there were still a number of CMSC measures that appeared to have been incorrectly designated as outcomes, since they continued to reflect expectations for ISP requirements or for timeliness of actions by the RST rather than outcomes for individuals. These are highlighted in the charts by bold italicized font. At the same time, the PCC KPA designated two measures as outputs, when they appeared to show outcomes for individuals (i.e., increased access to services, including integrated services.). These are highlighted in italicized font.	

Compliance Indicator	Facts	Analysis	Conclusion

Safety and freedom from harm

PMI	Defined Measure Type
1. HSWB KPA: For 95% of individual service recipients, seclusion or restraints are only utilized after a hierarchy of less restrictive interventions are tried (apart from crises where necessary to protect from an immediate risk to physical safety), and as outlined in human rights committee-approved plans	Outcome
2. RMRC: State policies and procedures for the use or prohibition of restrictive interventions (including seclusion) are followed.	Output
3. RMRC: State policies and procedures for the use or prohibition of restrictive interventions (including restraint) are followed.	Output
4. RMRC: Licensed providers meet the regulatory requirements for quality improvement programs.	Output
5. RMRC: Individuals are free from harm, as reflected in the rates of serious incidents that are related to risks which are prevalent in individuals with developmental disabilities; including: 1. aspiration pneumonia 2. bowel obstruction 3. sepsis 4. decubitus ulcer 5. fall or trip 6. dehydration 7. seizures 8. choking 9. urinary tract infection 10. self-injury 11. sexual assault 12. suicide attempt	Outcome

Compliance Indicator	Facts	Analysis		Conclusion
		6. RMRC: Corrective actions for substantiated cases of ANE are verified by DBHDS as being implemented (DBHDS verifies that providers' corrective actions for substantiated case of ANE are implemented)	Output	
		7. RMRC: Critical incidents are reported to OL within the required timeframes.	Output	
		8. RMRC: Licensed DD provider that administer medications are NOT cites for failure to review medication errors at least quarterly.	Output	
		9. RMRC: Provider investigations of abuse and neglect allegations are conducted in accordance with regulations of the Office of Human Rights.	Output	
		10. RMRC: The number of licensed providers, by service, that were determined to be compliant with each of the quality improvement regulations (620) during an unannounced annual inspection; reported separately.	Output	
		Physical, mental, and behavioral health and wellbeing		
		PMI	**Defined Measure Type**	
		1. CMSC: The case manager assesses whether the person's status or needs for services and supports have changed and the plan has been modified as needed.	Output	
		2. CMSC: Individual support plans are assessed to determine that they are implemented appropriately.	Output	
		3. HSWB KPA: Individuals on the DD waivers will have a documented annual1physical exam date.	Output	
		4. HSWB KPA: Individuals on the DD waivers will have an actual annual1physical exam date.	Output	
		5. MRC: Unexpected deaths where the cause of death, or a factor in the death, was potentially	Output	

Compliance Indicator	Facts	Analysis	Conclusion

preventable and some intervention to remediate was taken.	

Avoiding crises	
PMI	**Defined Measure Type**
1. Individuals who are admitted into REACH mobile crisis supports will have a CEPP completed within 15 days of their admission into the service	Output

Stability	
PMI	**Defined Measure Type**
1. CII KPA: Individuals have stability in independent housing	Outcome
2. CII KPA: Individuals on the DD waivers and waitlist are working in ISE or GSE for 12months or longer.	Outcome
3. CII KPA: Individuals on the DD waivers and known to REACH who are admitted to CTH facilities will have a community residence identified within 30 days of admission.	Output

Choice and Self-determination	
PMI	**Defined Measure Type**
1. CMSC: Individuals are given choice among providers, including choice of support coordinator, at least annually	Outcome
2. CMSC: Individuals participate in an annual discussion with their Support Coordinator about relationships and interactions with people (other than paid program staff).	***Outcome***
3. CII KPA: At least 75% of people receiving services who do not live in the family home/their	Outcome

Compliance Indicator	Facts	Analysis	Conclusion

authorized representatives chose or had some input in choosing where they live	

Community Inclusion	
PMI	**Defined Measure Type**
1. CII KPA: Individuals with an active waiver are involved in their community without barriers.	Outcome
2. CII KPA: Individuals with an active waiver are involved in their community through the most integrated support	Outcome
3. CII KPA: Individuals live in independent housing	Outcome
4. CMSC: Individuals aged 14-17 who are receiving waiver services will have a discussion about their interest in employment and what they are working on while at home and in school toward obtaining employment upon graduation, and how the waiver services can support their readiness for work, included in their ISP.	***Outcome***

Access to Services	
PMI	**Defined Measure Type**
1. CMSC: Adults (age 18-64) with a DD Waiver receiving case management services from the CSB whose ISP, developed or updated at the annual ISP meeting, contains employment outcomes, including outcomes that address barriers to employment.	***Outcome***
2. CMSC: Regional Support Team referrals are timely for individuals considering a move into group homes of 5 or more beds	***Outcome***
3. CMSC: Regional Support Team (RST) non-emergency referrals are made in sufficient time for	***Outcome***

Compliance Indicator	Facts	Analysis		Conclusion
		the RSTs to meet and attempt to resolve identified barriers.		
		4. CMSC: Individuals receiving case management services from the CSB whose ISP, developed or updated at the annual ISP meeting, contained Medicaid DD Waiver Community Engagement/or Community Coaching services goals	***Outcome***	
		5. PCC KPA: Data continues to indicate an annual 2% increase in the overall DD waiver population receiving services in the most integrated settings.	Outcome	
		6. PCC KPA: Data continues to indicate that at least 90% of individuals new to the waivers, including for individuals with a "supports need level" of 6 or 7, since FY16 are receiving services in the most integrated setting.	*Output*	
		7. PCC KPA: The Data Summary indicates an increase in services available by locality over time.	*Output*	
		8. PCC KPA: Assess if transportation provided by waiver service providers (not to include NEMT) is being provided to facilitate individuals' participation in community activities and Medicaid services per their ISPs.	Output	
		Provider Capacity		
		PMI	**Defined Measure Type**	
		1. PCC KPA: Provider investigations of abuse and neglect allegations are conducted in accordance with regulations of the Office of Human Rights.	Output	
		2. PCC KPA: People with DD waiver are supported by trained, competent Direct Support Professionals (DSPs).	Output	
		3. CMSC: Individuals receiving Developmental Disability case management services identified as	***Outcome***	

Compliance Indicator	Facts	Analysis	Conclusion
		meeting ECM criteria will receive face to face visits every other month in their residence. 4. CMSC: Individuals meeting ECM criteria receive F2F visits every other month — ***Outcome***	
36.05: Each KPA PMI contains the following: a. Baseline or benchmark data as available. B. The target that represents where the results should fall at or above. C. The date by which the target will be met. D. Definition	The updated *Technical Guidance for Measure Development*, as of 7/26/21, addressed each of the requirements a-e listed in this CI.	At the time of the previous review, the Office of DQV had provided the *Technical Guidance for Measure Development* for use by DBHDS staff for measure development, accompanied by a Measure Development Template. For this review, the Office of DQV had updated the *Technical Guidance for Measure Development* as of 7/26/21, which now included some additional instruction with regard to the data collection methodology, as described further below. Overall, the guidance addressed each of the requirements of 36.05, as follows: • Measure Steward: Each PMI has a measure, or data, steward. This is the team member responsible for the measure details provided in this	17th Not Met 19th Not Met

Compliance Indicator	Facts	Analysis	Conclusion
of terms included in the PMI and a description of the population. E. Data sources (the origins for both the numerator and the denominator) f. Calculation (clear formulas for calculating the PMI, utilizing a numerator and denominator). G. Methodology for collecting reliable data (a complete and thorough description of the specific steps used to supply the numerator and denominator for calculation). H. The subject matter expert (SME) assigned to report and enter data for each PMI. i. A Yes/No indicator to show whether the PMI can provide regional breakdowns.	While DBHDS provided a template for each PMI, as described above with regard to CI 36.01, some were incomplete. In addition, as the DBHDS guidance *Technical Guidance for Measure Development* required, the Office of DQV had not completed the recommendations section or had not documented a current review, either annually, or as needed to address modifications a Data Steward had made.	document. They are also responsible for reporting data and monitoring progress towards the goal. • Approval Date and Implementation: The Quality Improvement Committee (QIC) approval date a confirmation of the state fiscal year of data collection that this measure is considered 'active.' If the measure is 'retired,' the final state fiscal year of data collection would be indicated here as well. If the measure was changed, a reference to the sister measure may be included here. • Data Source: The source(s) where the original data is maintained (e.g., a specific database, a data warehouse report, the name of a specific spreadsheet). If someone other than the measure steward is responsible for maintaining or reporting out this data, it may be described here. • Methodology: Description of the data reporting details (e.g., inclusion codes). This section may also include calculation steps, including details regarding how and when the data will be collected. Of note, the previous review found that DBHDS staff could benefit from expanded guidance with regard to the methodology; specifically, that the methodology should include the details regarding how and when the data would be collected. For example, Independent Reviewer reports had previously stated that the methodology should specifically describe how the data will be collected (e.g., through a monitoring tool, through review of records, through review of the implementation of individuals' ISPs, etc.) and by whom, when and how often the data will be pulled/aggregated (e.g., monthly, quarterly, end of month, within first five days of month for preceding month, etc.), and the process and schedule for assessing data reliability, including who will be responsible for it. So, it was positive to see the updated *Technical Guidance for Measure Development* included this detail. However, as described in detail for CI 36.01, some PMIs did not have completed data collection methodologies.	

Compliance Indicator	Facts	Analysis	Conclusion
		In addition, the DBHDS *Technical Guidance for Measure Development* required that the Office of DQV assess threats to reliability and validity and offer recommendations that the Data Steward might choose to implement in order to improve PMI data quality and reliability. However, as described in detail for CI 36.01, for some PMIs, the Office of DQV had not completed the recommendations section or had not documented a current review, either annually, or as needed to address modifications to the methodology the Data Steward had made. • Regional Breakdown: Indicates whether the measure can provide regional data breakdowns. • Population: A description of the population, or subpopulation (e.g., percentage of the population), included in the measure. This could be individuals or providers. • Goal & Timeline: The goal for where the results should fall at or above, and the date by which it will be met. • Baseline: The current baseline data or most recent data. • Business Definitions & Processes: Definition of terms included in the measure/indicator for any terms that could be interpreted in more than one way. Other information related to specific business knowledge required to understand the importance and use of the measure in determining programmatic goals would be included here. This section may also include additional notes, ideas, issues or concerns that may be addressed at a later time by the KPA Workgroup.	
36.06: DBHDS in accordance with the Quality Management Plan utilizes a system for tracking PMIs and the	DBHDS was using a system for tracking PMIs as described in the *Quality Management Plan*.	DBHDS was using a system for tracking PMIs as described in the *Quality Management Plan SFY 2020*. The plan described procedures to track the efficacy of preventative, corrective, and improvement measures. In addition, CI 36.02, CI 36.04 above and CI 36.07 below provide examples with regard to how DBHDS quality committees and workgroups currently use this information with its QIC to identify areas of needed	17th Not Met 19th Not Met

Compliance Indicator	Facts	Analysis	Conclusion
efficacy of preventative, corrective, and improvement measures, and develops and implements preventative, corrective, and improvement measures where PMIs indicate health and safety concerns. DBHDS uses this information with its QIC or other similar interdisciplinary committee to identify areas of needed improvement at a systemic level and makes and implements recommendations to address them.	DBHDS described in the Quality Management Plan procedures to track the efficacy of preventative, corrective, and improvement measures, and through its various committees and workgroups, including but not limited to the QIC, to develop and implement preventative, corrective, and improvement measures where PMIs indicated health and safety concerns. However, based on the facts described for CI 36.01 and CI 38.01, the data reviewed cannot be confirmed to be valid and reliable and cannot be used for compliance reporting.	improvement at a systemic level and to make and implement recommendations to address them. However, based on review of a PowerPoint document entitled *Concept Report Template to the QIC*, dated September 27, 2021, DBHDS was planning to implement a modified approach to reviewing the efficacy of preventative, corrective, and improvement measures, and developing and implements preventative, corrective, and improvement measures. The slides indicated this would begin in the second quarter of the SFY 2022, and was intended to address the tendency toward a siloed approach to KPA domains. Instead, this new approach will acknowledge that subcommittees and workgroups often have PMIs that cross over the assigned domains (i.e., as illustrated in the charts for CI 31.06 above.). The concept new would focus reporting on the KPA domain, including relevant PMIs from all applicable committees and workgroups, as well as NCI and QSR findings, and bring together in one place to facilitate a comprehensive discussion and answer the question 'How are we doing in this KPA?' Overall, this appeared to be a well-thought out strategy and held promise for enhancing an interdisciplinary approach to identifying areas of needed improvement at a systemic level and making and implementing recommendations to address them. However, these functions require valid and reliable data as a foundation to accurate decision-making. At the time of this review, based on the facts described for CI 36.01 above and CI 38.01 below, the data reviewed cannot be confirmed to be valid and reliable and cannot be used for compliance reporting.	

Compliance Indicator	Facts	Analysis	Conclusion
36.07: DBHDS demonstrates annually at least 3 ways in which it has utilized data collection and analysis to enhance outreach, education, or training.	At the QIC meeting on June 28, 2021, DBHDS KPA workgroups, the RMRC, MRC and CMSC all offered PowerPoint presentations for the 4th quarter of SFY21. These presentations detailed the QIIs implemented during SFY 2021 and described many ways in which they used data collection and analysis to enhance outreach, education, or training. However, based on the facts described for CI 36.01 and CI 38.01, DBHDS had still not confirmed the data to be valid and reliable and, therefore, it cannot be used for compliance reporting.	At the time of the 17th Period review, DBHDS had demonstrated annually at least 3 ways in which it had utilized data collection and analysis to enhance outreach, education, or training. However, at that time, DBHDS had not verified the data sources as reliable and valid, which is required to use the data for compliance reporting. For this review, at the QIC meeting on June 28, 2021, DBHDS KPA workgroups, the RMRC, MRC and CMSC all offered PowerPoint presentations for the 4th quarter of SFY21. These presentations detailed the QIIs implemented during SFY 2021 and described ways in which they data collection and analysis to enhance outreach, education, or training. Examples are provided below. • The KPA Workgroups reported the following activities: o For the Crisis Assessment QII, data indicated that providers had difficulty accessing related training and additional training was needed. In response, DBHDS provided additional training on crisis risk awareness tool as well as additional follow up to CSBs regarding the review of the tools. o For the Independent Housing QII, OCH used the housing outcomes data to develop a ranking of CSBs for the. first time. Each CSB received their data and ranking of all CSBs. In addition, in collaboration with the Office of Provider Development, OCH hosted a Virtual Independent Housing Exploration Series in March 2021 o For the DSP QII Competency QII, DBHDS developed DSP Training and Competencies Webinars, provided regionally, which were recorded. The slides and Q&A were to be posted online. • The RMRC reported the following examples: o Based on its review of data for 327 UTI reports, from the period 10/1/19 through 9/30/20, in March 2021, OIH published an updated Health and Safety Alert on Urinary Tract Infections, and focused on National Kidney Month in the OIH Health Trends Newsletter. In addition, they made plans to review and update existing provider training and educational resources (e.g., atypical signs and symptoms of UTI; Skill building related to personal care/hygiene; discussing body parts; health literacy; how other diagnoses, diseases, and medications interplay with a diagnosis of a UTI, etc.) • The CMSC reported the following examples:	17th Not Met 19th Met*

Compliance Indicator	Facts	Analysis	Conclusion
		○ Data collected through the SCQR was used in the provision of technical assistance across CSBs and contributed to the enhancement of the ISP and related training materials. ○ Data collected through the On-Site Visit Tool (OSVT) pilot resulted in revised forms and related training and guidance. ○ Data related to late RST referrals led to discussions with Regional Quality Councils to increase awareness and collect suggestions for further evaluation. • The MRC reported its MRC Sepsis Awareness QII resulted in the provision of Sepsis Training to 201 participants on 6/4/21.	
36.08: DBHDS collects and analyzes data (at minimum a statistically valid sample) at least annually regarding the management of needs of individuals with identified complex behavioral, health and adaptive support needs to monitor the adequacy of management and supports provided. DBHDS develops corrective action(s) based on its analysis, tracks the efficacy of that action, and revises as necessary to ensure that the action addresses the deficiency.	For this review period, DBHDS did not submit documentation to show it complied with these requirements or had developed a plan to do so.	At the time of the 17th Period review, the study found that the methodology for implementation of this requirement appeared to be a work in progress. DBHDS staff reported they were examining opportunities to use case management functions to identify the needs of individuals with identified complex behavioral, health and adaptive support needs to monitor the adequacy of management and supports provided. In particular, DBHDS staff were focusing on how to use data from the Risk Assessment Tool (RAT) and the On-Site Tool (i.e., used by Support Coordinators to document key facets of the face-to-face visits), to flesh out this plan. Based on documents available for review from August 2020, DBHDS had also developed a draft document entitled *Protocol for the Identification and Monitoring of Individuals with Complex Behavioral, Health, and Adaptive Support Need sand the Development of Corrective Action Plans required to Address Instances Where the Management of Needs for These Individuals Falls Below Identified Expectations for the Adequacy of Management and Supports Provided*, with a protocol development date of May 29, 2020. It described a set of steps for development and implementation necessary to implement the requirements of CI 36.08. These began with the OIH, the Office of Community Support Services and the Office of Provider Development working with the Office of DQV to determine a sampling methodology, to review the results of the sampling to determine if supports and recommendations were appropriately implemented; to utilize data from the Support Coordinator Quality Review process and Quality Service Review process to validate findings and implement corrective actions; and, to make recommendation for improvement to the provider as well as identify patterns and recommend systemic	17th Not Met 19th Not Met

Compliance Indicator	Facts	Analysis	Conclusion
		improvements. The draft document further proposed that data from all of these reviews would be shared with the Case Management Steering Committee, Quality Review Team, and Quality Management Review Team to assure a comprehensive set of strategies are developed to address these support needs. However, for this review period, DBHDS did not submit this document or any other documentation to show it complied with these requirements or had developed a plan to do so. It appeared that some good thought had gone in to developing the draft protocol above and, in the absence of any other strategies, DBHDS should consider re-visiting this draft protocol.	

V.D.3 Analysis of 19th Review Period Findings

Section V.D.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 wellbeing (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)**

Compliance Indicator	Facts	Analysis	Conclusion
37.01: DBHDS has established three Key Performance Areas (KPAs) that address the eight domains listed in V.D.3.a-h. DBHDS quality committees and workgroups, including Mortality Review Committee, Risk Management Review Committee, Case Management Steering Committee and KPA	DBHDS has established three Key Performance Areas (KPAs) that address the eight domains listed in V.D.3.a-h. As detailed with regard to CI 36.04 above, DBHDS established performance measure indicators (PMIs) that are in alignment with the eight domains that are reviewed by the DBHDS Quality	As detailed in the *DBHDS Quality Management Plan SFY20,* with an effective date of 3/31/21, DBHDS had established three Key Performance Areas (KPAs) that address the eight domains listed in V.D.3.a-h. The KPA workgroups and assigned domains are as follows: A. The Health, Safety and Well Being KPA workgroup encompasses the domains of: a) Safety and Freedom from Harm, b) Physical, Mental, and Behavioral Health and Well-being and c) Avoiding Crises B. The Community Integration and Inclusion KPA workgroup encompasses the domains of: a) Community Inclusion, b) Choice and Self-Determination and c) Stability C. The Provider Competency and Capacity KPA workgroup encompasses the domains of: a) Provider Capacity and b) Access to Services	17th undetermined 19th Met*

Compliance Indicator	Facts	Analysis	Conclusion
workgroups, establish performance measure indicators (PMIs) that are in alignment with the eight domains that are reviewed by the DBHDS Quality Improvement Committee (QIC). The components of each PMI are set out in indicator #5 of V.D.2. The DBHDS quality committees and workgroups monitor progress towards achievement of PMI targets to assess whether the needs of individuals enrolled in a waiver are met, whether individuals have choice in all aspects of their selection of their services and supports, and whether there are effective processes in place to monitor individuals' health and safety. DBHDS uses these PMIs to recommend and prioritize quality improvement initiatives to address identified issues	Improvement Committee (QIC). However, as described for CI 36.01 above and CI38.01 below, deficiencies remained with regard to the availability of reliable and valid data. As a result, while the DBHDS quality committees and workgroups regularly reviewed data for the PMIs, the data cannot be used to confirm compliance.	As described in detail with regard to CI 36.01 and CI 36.04 above, DBHDS quality committees and workgroups have established performance measure indicators (PMIs) that are in alignment with the eight domains. CI 36.02, CI 36.04, CI 36.06 and CI 36.07 above provide details with regard to how DBHDS quality committees and workgroups monitor progress towards achievement of PMI targets and to recommend and prioritize quality improvement initiatives to address identified issues However, as described for CI 36.01 above and CI 38.01 below, deficiencies remained with regard to the availability of reliable and valid data. As a result, while the DBHDS quality committees and workgroups regularly reviewed data for the PMIs, the data cannot be used to confirm compliance.	
37.02: The assigned committees or workgroups report to the	The QIC workgroups reported to the QIC on identified PMIs,	For this review, as described above with regard to CI 36.02, CI 36.04, CI 36.06 and CI 36.07. Based on the QIC minutes reviewed for the dates of June 28, 2021, and	17th undetermined

Compliance Indicator	Facts	Analysis	Conclusion
QIC on identified PMIs, outcomes, and quality initiatives. PMIs are reviewed at least annually consistent with the processes outlined in the compliance indicators for V.D.2. Based on the review and analysis of the data, PMIs may be added, deleted, and/or revised in keeping with continuous quality improvement practices.	outcomes, and quality initiatives. However, as described in detail with regard to CI 36.01 above, DBHDS did meet the second requirement of this CI. It did not consistently complete a review of PMIs least annually that was consistent with the processes outlined in the compliance indicators for V.D.2. (i.e., CI36.01), which requires that an evaluation of each PMI occurs at least annually and includes a review of, at minimum, data validation processes, data origination, and data uniqueness. Many PMIs did not have a current annual review. In addition, as described for CI 36.01 above and CI38.01 below, deficiencies remained with regard to the availability of reliable and valid data. As a result, while the DBHDS quality committees and	9/27/2021, the QIC workgroups and committees reported to the QIC on identified PMIs, outcomes, and quality initiatives. As described in detail with regard to CI 36.01 above, DBHDS did not consistently complete a review of PMIs least annually and consistent with the processes outlined in the compliance indicators for V.D.2. (i.e., CI36.01), which requires that an evaluation of each PMI occurs at least annually and that includes a review of, at minimum, data validation processes, data origination, and data uniqueness. Many PMIs did not have a current annual review. In addition, as described for CI 36.01 above and CI3 8.01 below, deficiencies remained with regard to the availability of reliable and valid data. As a result, while the DBHDS quality committees and workgroups regularly reviewed data for the PMIs, the data cannot be used to confirm compliance.	19th Not Met

Compliance Indicator	Facts	Analysis	Conclusion
	workgroups regularly reviewed data for the PMIs, the data cannot be used to confirm compliance.		
37.03 The KPA workgroups and assigned domains (V.D.3.a-h) are: A. Health, Safety and Well Being KPA workgroup encompasses the domains of: a) Safety and Freedom from Harm b) Physical, Mental, and Behavioral Health and Well-being c) Avoiding Crises B. Community Integration and Inclusion KPA workgroup encompasses the domains of: a) Community Inclusion b) Choice and Self-Determination c) Stability C. Provider Competency and Capacity KPA workgroup encompasses the domains of: a) Provider Capacity b) Access to Services.	As required by CI 37.03,the *Quality Management Plan SFY 2020*, dated 3/31/21, the KPA workgroup charters and DI 316 assigned the respective domains to each KPA.	As described with regard to CI 37.01, above the KPA workgroups and assigned domains are as follows: D. The Health, Safety and Well Being KPA workgroup encompasses the domains of: a) Safety and Freedom from Harm, b) Physical, Mental, and Behavioral Health and Well-being and c) Avoiding Crises E. The Community Integration and Inclusion KPA workgroup encompasses the domains of: a) Community Inclusion, b) Choice and Self-Determination and c) Stability F. The Provider Competency and Capacity KPA workgroup encompasses the domains of: a) Provider Capacity and b) Access to Services. In addition, each KPA had a current charter that reiterated these assignments. The most recent charters were dated 9/21/21.	17th Met 19th Met
37.04: The DBHDS Quality Management Plan details the quality committees, workgroups, procedures and processes	The DBHDS Quality Management Plan details the quality committees, workgroups, procedures and processes for	As reported at the time of the 17th Period review, the DBHDS *Quality Management Plan SFY 2019* detailed the quality committees and workgroups. For this review, *Quality Management Plan SFY 2020* described the quality workgroups and committees as follows:	17th Not Met 19th Met

Compliance Indicator	Facts	Analysis	Conclusion
for ensuring that the committees and/or workgroups establish PMIs and quality improvement initiatives in the KPAs on a continuous and sustainable basis.	ensuring that the committees and/or workgroups establish PMIs and quality improvement initiatives in the KPAs on a continuous and sustainable basis.	• The RMRC shall provide ongoing monitoring of incident data, including serious incidents and allegations and substantiations of abuse, neglect, and exploitation; and analysis of individual, provider, and system level data to identify trends and patterns and make recommendations to promote health, safety, and well-being of individuals. As a subcommittee of the QIC, the RMRC identifies and addresses risks of harm; ensures the sufficiency, accessibility, and quality of services to meet individuals' needs in integrated settings; and collects and evaluates data to identify and respond to trends to ensure continuous quality improvement. The RMRC ensures that approved quality improvement initiatives are implemented and reported to the QIC. • The MRC shall focus on system-wide quality improvement by conducting mortality reviews of deaths of individuals of individuals with DD reported to DBHDS through its incident reporting system. • The CMSC oversees and coordinates various activities to strengthen the case management system and collaborates with the Provider Capacity and Competency Workgroup. The committee's overall goals are to: o Ensure and oversee the coordination of all internal and external quality improvement activities that affect both the transactional and transformational components of case management; o Identify strengths, weaknesses, and gaps in newly implemented products and processes; and o Make recommendations for system improvement. • The Health, Safety, and Wellbeing Workgroup is responsible for the collection and analysis of data as it relates to helping individuals achieve positive health outcomes, remain safe from harm, and avoid crises. The workgroup establishes goals and performance measures related to physical, mental, and behavioral health well-being. Data related to prevention strategies, wellness trends, and clinical outcomes are monitored. • The Community Inclusion and Integrated Settings Workgroup is charged with promoting stable service provision in the most integrated settings appropriate to each individual's needs and consistent with the individual's informed choice and ensuring full access and participation in community life. The workgroup establishes goals and performance measures to help ensure the most integrated settings appropriate to the individuals' needs, community stability, individual choice, self-determination, and community inclusion.	

Compliance Indicator	Facts	Analysis	Conclusion
		• The Provider Capacity and Competency Workgroup is charged with improving availability of and access to services across the Commonwealth and facilitating provider training, competency, and quality service provision. The workgroup establishes goals and performance measures related to provider capacity, access to services, and provider competency. The *Quality Management Plan SFY 2020* also referenced procedures and processes for ensuring that the committees and/or workgroups establish PMIs and quality improvement initiatives in the KPAs on a continuous and sustainable basis. Pursuant to the responsibilities delegated in the *Quality Management Plan*, DBHDS staff had established timeframes for reporting and developed several tools and processes to support the work of the committees and workgroups. These included, but were not limited to, the *Technical Guidance for Measure Development*, the Quality Improvement Initiative (QII) toolkit, the PMI template and QIC reporting templates. While overall it appeared DBHDS met the intent of this CI, some worked continued to be needed. For example, as described with regard to CI 36.08 above, DBHDS had not yet developed a protocol to collect and analyzes data (at minimum a statistically valid sample) at least annually regarding the management of needs of individuals with identified complex behavioral, health and adaptive support needs to monitor the adequacy of management and supports provided.	
37.05: Each KPA workgroup will: a) Establish at least one PMI for each assigned domain b) Consider a variety of data sources for collecting data and identify the data sources to be used c) Include baseline data, if available and applicable, when establishing performance measures d) Define measures and the methodology for	As detailed in the charts for CI 36.01, each KPA workgroup established at least one PMI for each assigned domain, as required in sub-indicator a). Each KPA workgroup engaged in activities to implement sub-indicators b) through c) and e) through i). However, for sub-indicator d) (i.e.,	As detailed in the chart for CI 36.04 above, each KPA workgroup established at least one PMI for each assigned domain, as required in sub-indicator a). Based on review of the workgroup and QIC minutes, as well as the PMI Templates for 35 (with two duplicates) PMIs DBHDS submitted for review, each KPA workgroup considered a variety of data sources for collecting data and identify the data sources to be used, as required by sub-indicator b); included baseline data, if available and applicable, when establishing performance measures, as required by sub-indicator c); established a target and timeline for achievement, as required by sub-indicator e); measured performance across each domain, as required by sub-indicator f); analyzed data and monitored for trends, as required by sub-indicator g) recommended quality improvement initiatives as required by sub-indicator h); and reported to the QIC for oversight and system-level monitoring, as required by sub-indicator i).	17th Not Met 19th Not Met

Compliance Indicator	Facts	Analysis	Conclusion
collecting data e) Establish a target and timeline for achievement f) Measure performance across each domain g) Analyze data and monitor for trends h) recommend quality improvement initiatives i) Report to DBHDS QIC for oversight and system-level monitoring	define measures and the methodology for collecting data), as described with regard to CI 31.06 above, DBHDS did not consistently fully define the methodology for collecting data for all PMIs. Based on the failure to consistently fully define the methodology for collecting data for all PMIs and the continuing deficiencies in the data source systems, as described for CI 36.01 and CI 38.01, the data reviewed cannot be confirmed to be valid and reliable and cannot be used to confirm compliance.	However, overall, DBHDS did not achieve compliance for CI 37.05. For sub-indicator d) (i.e., define measures and the methodology for collecting data), as described with regard to CI 31.06 above, DBHDS did not consistently fully define the methodology for collecting data for all PMIs. In combination with the deficiencies in availability of valid and reliable data (e.g., for the data source systems), as described with regard to CI 31.06 and 38.10, would cause similar validity and reliability concerns for the results of the measurement, monitoring and analysis processes. This, in turn, negatively impacts the decision-making process with regard to recommending quality improvement initiatives. Accordingly, the PMI data cannot be used to confirm compliance.	
37.06: DBHDS collects and analyzes data from each domain listed in V.D.3.a-h. Within each domain, DBHDS collects data regarding multiple areas. Surveillance data is collected from a variety of data sources as described in the Commonwealth's	As described in detail below, DBHDS workgroups and committees collected surveillance data from a variety of data sources. Based on review of minutes and surveillance data reporting provided for review, DBHDS	At the time of the 17th Period review, DBHDS was collecting and analyzing data from each domain, but the efforts were compromised by the lack of valid and reliable data. For this review, as described in detail below (i.e., for CI 37.09, CI 37.11, CI 37.13, CI 37.15, CI 37.17, CI 37.19, CI 37.21 and CI 37.23), DBHDS workgroups and committees collected surveillance data from a variety of data sources. DBHDS provided a document entitled *SFY21 KPA Schedule Surveillance Data,* updated December 2020. This document provided staff with an outline of appropriate steps to follow when reviewing the data for the purposes of analysis and interpretation.	17th Not Met 19th Not Met

Compliance Indicator	Facts	Analysis	Conclusion
indicators for V.D.3.a-h. This data may be used for ongoing, systemic collection, analysis, interpretation, and dissemination and also serves as a source for establishing PMIs and/or quality improvement initiatives.	workgroups and committees reviewed the data on at least a semiannual basis and used the data to consider establishment of PMIs and/or quality improvement initiatives. However, based on the failure to consistently fully define the methodology for collecting data for all PMIs and the continuing deficiencies in the data source systems, as described for CI 36.01 and CI 38.01, the data reviewed cannot be confirmed to be valid and reliable and cannot be used to confirm compliance.	1. Look at what trends are appearing. Highlight any patterns. Are there any gaps or disparities in the data? Remember to look at age, gender, race/ethnicity, region/locality and type of residence as these provide additional context. There may be other data elements that are important to consider. 2. Are there are any surprises or pieces that don't make sense? Other anomalies? 3. What might this data tell us about our service system? How might we use this information? 4. Are there common elements across reports that may provide additional information or that may support what is happening? 5. Is there cause for concern such that action (developing a PMI or QII) is needed? Based on review of minutes and surveillance data reporting provided for review, DBHDS workgroups and committees reviewed the data on at least a semiannual basis and used the data to consider establishment of PMIs and/or quality improvement initiatives. However, based on the failure to consistently fully define the methodology for collecting data for all PMIs and the continuing deficiencies in the data source systems, as described for CI 36.01 and CI 38.01, the data reviewed cannot be confirmed to be valid and reliable and cannot be used to confirm compliance.	
37.07: The Office of Data Quality and Visualization will assess data quality and inform the committee and workgroups regarding the validity and reliability of the data sources used in accordance with V.D.2 indicators 1 and 5.	V.D.2 indicator 1 (i.e., CI 36.01) and V.D.2 indicator 5 (i.e., CI 36.05) require the development a Data Quality Monitoring Plan to ensure that it is collecting and analyzing consistent reliable data, including an annual evaluation; specify that data sources will not	V.D.2 indicator 1 (i.e., CI 36.01) requires that DBHDS develops a Data Quality Monitoring Plan to ensure that it is collecting and analyzing consistent reliable data. Under the Data Quality Monitoring Plan, DBHDS assesses data quality, including the validity and reliability of data and makes recommendations to the Commissioner on how data quality issues may be remediated. It also requires that this evaluation occurs at least annually and includes a review of, at minimum, data validation processes, data origination, and data uniqueness. Further, it specifies that data sources will not be used for compliance reporting until they have been found to be valid and reliable. V.D.2 indicator 5 (i.e., CI 36.05) requires that each KPA PMI describes key elements needed to ensure the data collection methodology produces valid and reliable data	17th Not Met 19th Not Met

Compliance Indicator	Facts	Analysis	Conclusion
	be used for compliance reporting until they have been found to be valid and reliable; and, requires that each KPA PMI describes key elements needed to ensure the data collection methodology produces valid and reliable data. For this review, as described in detail with regard to CI 36.01 and CI 38.01, the Office of DQV did not consistently complete annual assessments of data quality of either the source systems or the PMI data collection methodologies. Therefore, the data sources cannot be used for compliance reporting at this time.	(e.g., definitions of key terms, data sources, set targets, etc.). It also requires that each PMI describe a complete and thorough description of the specific steps used to supply the numerator and denominator for calculation. For this review, as described in detail with regard to CI 36.01 and CI 38.01, the Office of DQV did not consistently complete annual assessments of data quality of either the source systems or the PMI data collection methodologies. As a result, the Office of DQV could not reliably inform the committee and workgroups regarding the validity and reliability of the data sources. However, as described with regard to CI 36.01 above, while the Office of DQV acknowledged that the recommendations from the original version of the *Data Quality Monitoring Plan* had not yet been addressed in a comprehensive manner, it was positive that the Office of DQV developed a plan for addressing those.	
37.08: The Quality Management Annual Report will describe the accomplishments and barriers for each KPA.	DBHDS issued a *Quality Management Annual Report State Fiscal Year 2020*, dated 3/31/21, that described the accomplishments and barriers for each KPA.	At the time of the 17th Period review, DBHDS had issued a *Quality Management Plan: Annual Report and Evaluation State Fiscal Year 2019*. It described the accomplishments and barriers for each KPA defined in the compliance indicator, but the information and data were dated, covering a period from 7/1/18 through 6/30/19. As reported at the time of the 18th Period review, DBHDS had issued the *Quality Management Plan SFY 2020,* dated 3/31/21, covering a period from 7/1/19 through 6/30/20. At that time, the Report had been disseminated on 4/1/21 through the	17th Not Met 19th Met

<table>
<tr><th>Compliance Indicator</th><th>Facts</th><th>Analysis</th><th>Conclusion</th></tr>
<tr><td></td><td></td><td>Provider List serv, which includes providers, case managers, and other stakeholders. It was positive to see that DBHDS staff had accelerated the timeframe for production and distribution of the Report to nine months after the period from approximately 12 months for the previous Report, such that the information was not as dated as for previous periods. However, they still needed to consider moving the timeframe for report production further forward, such that stakeholders received more recent information.

For this review, the Quality Management Annual Report State Fiscal Year 2020, dated 3/31/21, remained the current version. It described the accomplishments and barriers for each KPA. Based on interview with DBHDS staff, they did not expect the next version to be issued before December 2021 or January 2022. If this target timeframe is met, it would result in making more recent information available, as previously recommended.</td><td></td></tr>
<tr><td>37.09: The Health, Safety and Well Being KPA workgroup will finalize surveillance data to be collected for “safety and freedom from harm,” at minimum including: a. Neglect and abuse b. Injuries c. Use of seclusion or restraints d. Effectiveness of corrective action e. Licensing violations f. Deaths</td><td>The HSWB KPA workgroup proposed surveillance data to be collected for “safety and freedom from harm.” These addressed all of the minimum criteria for CI 37.09.</td><td>As illustrated below, the HSWB KPA workgroup proposed surveillance data to be related “safety and freedom from harm.” These addressed all of the minimum criteria for CI 37.09, including a. Neglect and abuse; b. Injuries; c. Use of seclusion or restraints; d. Effectiveness of corrective action; e. Licensing violations and f. Deaths.
<table>
<tr><th>Type of Data</th><th>Required Surveillance Data Report for Review</th><th>Data Elements to Review</th></tr>
<tr><td>Neglect and abuse</td><td>Annual RMRC Report with additional data pullfrom CHRIS, DW 38, DW33</td><td>Provider, individual, type of waiver, type of abuse, substantiated,region, CSB,FIPS code,</td></tr>
<tr><td>Injuries</td><td>Annual RMRC Report with additional data pullfrom CHRIS, DW80a</td><td>Incident by type, region , most frequent</td></tr>
<tr><td>Use of seclusion of restraints</td><td>Use Annual RMRC Report with additionaldata pull from CHRIS,</td><td>Provider, individual, type of waiver, type of abuse, substantiated,region, CSB,FIPS code</td></tr>
</table></td><td>17th Not Met

19th Met</td></tr>
</table>

<table>
<tr><th>Compliance Indicator</th><th>Facts</th><th>Analysis</th><th>Conclusion</th></tr>
<tr><td></td><td></td><td>
<table>
<tr><td></td><td>DW 38, DW33</td><td></td></tr>
<tr><td>Effectiveness of corrective actions</td><td>DW-0058 * Report being revised/updated</td><td>Providers with repeat citations by region</td></tr>
<tr><td>Licensing violations</td><td>Adequacy of Supports Report</td><td>Most frequently cited regulations by region</td></tr>
<tr><td>Death</td><td>Annual Mortality Report</td><td>Mortality - aggregate trends and patterns for all individuals reviewed; total number of deaths and cause of deaths in DBHDS licensed residential settings; crude mortality rate for individualson DD HCBS waiver and receiving a licensed service; crude mortality rate by residential setting in aggregate known by DBHDS; crude mortality rate by age, gender, and race; analyses of patterns by age, gender, and race, residential settings and DBHDS facilities, service program and cause of death.
Licensing - name, provider, citation, CAP</td></tr>
</table>
</td><td></td></tr>
<tr><td>37.10: The Health, Safety and Well Being KPA workgroup will develop, initiate, and monitor performance measures with a set target. Measures may be selected from, but not limited to, any of the following data sets: Abuse, neglect and</td><td>The HSWB KPA workgroup and RMRC developed and initiated performance measures for “safety and freedom from harm.”

Each included a set target, or goal.</td><td colspan="2">As referenced in the corresponding chart for CI 36.01above, the HSWB KPA workgroup and RMRC developed and initiated performance measures for “safety and freedom from harm.” Each included a set target, or goal, and DBHDS assigned the HSWB KPA workgroup or RMRC to monitor each performance measure. In addition, based on a review of meeting minutes DBHDS submitted, the HSWB KPA, and RMRC respectively monitored each of the assigned performance measures

However, based on the findings for CI 36.01 and CI 38.01, the Office of DQV had not yet determined that the applicable data source systems and/or PMI data</td><td>17th Not Met

19th Met*</td></tr>
</table>

Compliance Indicator	Facts	Analysis	Conclusion
exploitation; Serious incidents and injuries (SIR); Seclusion or restraint; Incident Management; National Core Indicators – (i.e., Health, Welfare and Rights); DMAS Quality Management Reviews (QMRs)	DBHDS assigned HSWB KPA workgroup or RMRC to monitor each performance measure. Based on a review of meeting minutes DBHDS submitted, the HSWB KPA workgroup, the MRC and the CMSC respectively monitored each of the assigned performance measures. Based on the findings describe above for CI 37.15, and for CI 36.01 and CI 38.01, the Office of DQV had not yet determined that the applicable data source systems and/or PMI data collection methodologies produced valid and reliable data, so the data cannot be used to support compliance findings.	collection methodologies produced valid and reliable data, so the data cannot be used to support compliance findings.	

<table>
<tr><th>Compliance Indicator</th><th>Facts</th><th>Analysis</th><th>Conclusion</th></tr>
<tr><td>37.11: The Health, Safety and Well Being KPA workgroup will finalize surveillance data to be collected for “Physical, mental, and behavioral health and well-being.”</td><td>The HSWB KPA workgroup finalized surveillance data to be collected for ““Physical, mental, and behavioral health and well-being.” These addressed all of the minimum criteria for CI 37.11.</td><td>As illustrated below, the HSWB KPA workgroup finalized surveillance data to be collected for five measures related “Physical, mental, and behavioral health and well-being,” including: a. Access to medical care and b. timeliness and adequacy of interventions.
<table>
<tr><th>Type of Data</th><th>Required Surveillance Data Report for Review</th><th>Data Elements to Review</th></tr>
<tr><td>Access to medical care (including preventative care)</td><td>NCI Health</td><td>NCI - age, gender, race/ethnicity, type of residence, residential designation, questions related to receiving medical care including preventative exams</td></tr>
<tr><td>Access to dental care (not listed in provision language)</td><td>NCI Health
(dental) Mobile Dental Clinic</td><td>OIH dental: # active patients, # for fixed rate dentistry, # for sedation dentistry - community referral, # for Mobile Dentistry Program
SWVATC Clinic Transition Evaluation</td></tr>
<tr><td>Timeliness and adequacy of interventions (particularly in response to change in status)</td><td>SCQR
Licensing Look Behind
Use Adequacy of Supports Report</td><td>Summary of adequacy of individualized supports related to Health & Well-being</td></tr>
</table></td><td>17th Not Met

19th Met</td></tr>
<tr><td>37.12: The Health, Safety and Well Being KPA workgroup will develop, initiate, and monitor performance measures with a set target. Measures may be selected from, but not limited to, any of the following data sets: SIR; Enhanced Case Management (ECM); National Core Indicators – (i.e., Health,</td><td>The HSWB KPA workgroup, MRC and CMSC developed and initiated performance measures for “Physical, mental, and behavioral health and well-being.”

Each included a set target, or goal.

DBHDS assigned HSWB KPA workgroup, MRC</td><td>As referenced in the corresponding chart for CI 36.01above, the HSWB KPA, workgroup, MRC and CMSC developed and initiated performance measures for “Physical, mental, and behavioral health and well-being.” Each included a set target, or goal and DBHDS assigned the HSWB KPA workgroup, MRC or CMSC to monitor each performance measure. In addition, based on a review of meeting minutes DBHDS submitted, the HSWB KPA, MRC and CMSC respectively monitored each of the assigned performance measures

However, based on the findings for CI 36.01 and CI 38.01, the Office of DQV had not yet determined that the applicable data source systems and/or the PMI data collection methodologies produced valid and reliable data, so the data cannot be used to support compliance findings.</td><td>17th Not Met

19th Met*</td></tr>
</table>

<table>
<tr><th>Compliance Indicator</th><th>Facts</th><th>Analysis</th><th>Conclusion</th></tr>
<tr><td>Welfare and Rights); Individual and Provider Quality Service Reviews (QSRs); QMRs</td><td>or CMSC to monitor each performance measure.

Based on a review of meeting minutes DBHDS submitted, the HSWB KPA workgroup, the MRC and the CMSC respectively monitored each of the assigned performance measures.

Based on the findings describe above for CI 37.15, and for CI 36.01 and CI 38.01, the Office of DQV had not yet determined that the applicable data source systems and/or PMI data collection methodologies produced valid and reliable data, so the data cannot be used to support compliance findings.</td><td></td><td></td></tr>
<tr><td>37:13: The Health, Safety and Well Being KPA workgroup will finalize surveillance data to be collected for “avoiding crises,” at minimum including: a. Number of people using crisis</td><td>The HSWB KPA workgroup proposed surveillance data to be collected for ““avoiding crises.” These addressed all of the minimum criteria for CI 37.13</td><td>As illustrated below, the HSWB KPA workgroup finalized surveillance data to be collected for one measure related to “avoiding crises,” including: : a. Number of people using crisis services b. Age and gender of people using crisis services c. Known admissions to emergency rooms or hospitals d. Admissions to Training Centers or other congregate settings e. Contact with criminal justice system during crisis

<table><tr><th>Type of Data</th><th>Required Surveillance</th><th>Data Elements to Review</th></tr></table></td><td>17th Not Met

19th Met</td></tr>
</table>

<table>
<tr><th>Compliance Indicator</th><th>Facts</th><th>Analysis</th><th>Conclusion</th></tr>
<tr><td>services b. Age and gender of people using crisis services c. Known admissions to emergency rooms or hospitals d. Admissions to Training Centers or other congregate settings e. Contact with criminal justice system during crisis</td><td></td><td>
<table>
<tr><th></th><th>Data Report for Review</th><th></th></tr>
<tr><td>Number of people using crisis services</td><td>Annual Reach Report REACH</td><td>CSB, region, level of crisis service, age</td></tr>
<tr><td>Age and gender of people using crisis services</td><td>REACH annual report</td><td>Not currently;
Annual report does include gender and could
provider 3 age groupings (youth, transition, adult)</td></tr>
<tr><td>Known admissions to emergency rooms or hospitals</td><td>Annual Reach Report REACH</td><td>Location that crisis assessment occurs in</td></tr>
<tr><td>Admissions to Training Centers or other congregate settings</td><td>RST, PASRR</td><td>RST referrals to 5 or more beds; ICF?</td></tr>
<tr><td>Contact with criminal justice system during crisis</td><td>Annual Reach Report</td><td>Calls involving law enforcement</td></tr>
</table>
</td><td></td></tr>
<tr><td>37.14: The Health, Safety and Well Being KPA workgroup will develop, initiate, and monitor performance measures with a set target. Measures may be selected from, but not limited to, any of the following data sets: Crisis Data; QMRs; QSRs; Waiver Management System (WaMS); CHRIS</td><td>The HSWB KPA workgroup developed one performance measure for “avoiding crises.”

Each included a set target, or goal.

DBHDS assigned the HSWB KPA workgroup to monitor the performance measure.

Based on a review of meeting minutes DBHDS submitted, the HSWB KPA workgroup</td><td>As referenced in the chart for CI 36.01 above, the Health, Safety and Well Being KPA workgroup developed and initiated a performance measure for “avoiding crises.” It included a set target, or goal, and DBHDS assigned the HSWB KPA workgroup to monitor the performance measure. In addition, based on a review of meeting minutes DBHDS submitted, the HSWB KPA, monitored the assigned performance measure. However, based on the findings for CI 36.01 and CI 38.01, the Office of DQV had not yet determined that the applicable data source system produced valid and reliable data, so the data cannot be used to support compliance findings.</td><td>17th Not Met

19th Met*</td></tr>
</table>

<table>
<tr><th>Compliance Indicator</th><th>Facts</th><th>Analysis</th><th>Conclusion</th></tr>
<tr><td></td><td>monitored the performance measures.

Based on the findings describe above for CI 37.15, and for CI 36.01 and CI 38.01, the Office of DQV had not yet determined that the applicable data source systems and/or PMI data collection methodologies produced valid and reliable data, so the data cannot be used to support compliance findings.</td><td></td><td></td></tr>
<tr><td>37.15: The Community Inclusion/Integrated Settings KPA workgroup will finalize surveillance data to be collected for “stability,” at minimum including data related to living arrangement, providers, and participation in chosen work or day programs.</td><td>The CII KPA workgroup proposed surveillance data to be collected for “stability.” These addressed all of the minimum criteria for CI 37.15</td><td>As illustrated below, the CII KPA workgroup finalized surveillance data to be collected related to “stability,” including data related to living arrangement, providers, and participation in chosen work or day programs
<table>
<tr><th>Type of Data</th><th>Required Surveillance Data Report for Review</th><th>Data Elements to Review</th></tr>
<tr><td>Living arrangement (maintenance ofchosen living arrangement)</td><td>Housing and WaMS Integrated Residential Settings Report</td><td>Housing: name, common identifiers (SSN/DOB), lease date, lease end or termination date, date referral made, eligibility criteria, what criteria met, type of assistance requesting, if ineligible, why ineligible, desired locality, accessible unit, current living situation, partner agency and date of referral tothem, outcome of referral, info on unit, region, time frame it takes from partner agency till date of lease execution, date fortermination of assistance, reason & date if no longer participating, where did they go</td></tr>
</table></td><td>17th Not Met

19th Met</td></tr>
</table>

<table>
<tr><th>Compliance Indicator</th><th>Facts</th><th>Analysis</th><th>Conclusion</th></tr>
<tr><td></td><td></td><td>
<table>
<tr><td></td><td></td><td>afterwards,

Integrated Residential Settings Report - Name, setting type, number of beds, CSB, authorization date</td></tr>
<tr><td>Providers (maintenance of chosen livingarrangement, change in providers)</td><td>Integrated Residential Settings Report and WaMS RST data report</td><td>Name, setting type, number of beds, CSB, authorization date,address, prior/current bed size, address change</td></tr>
<tr><td>Chosen work or day program (work/other day program stability)</td><td>Integrated Employmentand Day Services Report</td><td>Employment Report: unique identifier, DOB, employment start date, type of employment, current wage per hour, typicalhours worked per week, and primary disability;

Integrated Day Services Report: number in group day, authorizations for community engagement and coaching</td></tr>
</table>
</td><td></td></tr>
<tr><td>37.16: The Community Inclusion/Integrated Settings KPA workgroup will develop, initiate, and monitor performance measures with a set target. Measures may be selected from, but not limited to, any of the following data sets: Employment; Housing; NCI – (i.e., Individual Outcomes); QSRs; WaMS</td><td>The CII KPA workgroup developed and initiated performance measures for “stability.”

Each included a set target, or goal. DBHDS assigned the CII KPA workgroup to monitor each performance measure.

Based on a review of meeting minutes DBHDS</td><td>As referenced in the corresponding chart for CI 37.15 above, the CII KPA workgroup developed and initiated performance measures for “stability.” Each included a set target, or goal, and DBHDS assigned the CII KPA workgroup to monitor each performance measure. In addition, based on a review of meeting minutes DBHDS submitted, the CII KPA monitored each of the assigned performance measures

However, based on the findings describe above for CI 37.15, and for CI 36.01 and CI 38.01, the Office of DQV had not yet determined that the applicable data source systems and/or PMI data collection methodologies produced valid and reliable data, so the data cannot be used to support compliance findings.</td><td>17th Not Met

19th Met*</td></tr>
</table>

<table>
<tr><th>Compliance Indicator</th><th>Facts</th><th>Analysis</th><th>Conclusion</th></tr>
<tr><td></td><td>submitted, the CII KPA monitored each of the assigned performance measures.

Based on the findings describe above for CI 37.15, and for CI 36.01 and CI 38.01, the Office of DQV had not yet determined that the applicable data source systems and/or PMI data collection methodologies produced valid and reliable data, so the data cannot be used to support compliance findings.</td><td></td><td></td></tr>
<tr><td>37.17: The Community Inclusion/Integrated Settings KPA workgroup will finalize surveillance data to be collected for “Choice and self-determination.”</td><td>The CII KPA workgroup proposed surveillance data to be collected for “choice and self-determination.”

However, the Workgroup had not finalized the data sets to be collected. They identified the type of data desired, but often did not identify where to obtain the data or the data elements to review.</td><td>As illustrated below, the CII KPA workgroup proposed surveillance data to be collected for “choice and self-determination.” However, it did not appear the Workgroup had finalized the data sets to be collected. They identified the type of data desired, but often did not identify where to obtain the data or the data elements to review.

<table><tr><th>Type of Data</th><th>Required Surveillance Data Report for Review</th><th>Data Elements to Review</th></tr><tr><td>Service plans developed through person-centered planning process</td><td>(blank)</td><td>(blank)</td></tr><tr><td>Choice of services and providers</td><td>SCQR data - Q24-Q26</td><td>CSB, name, sex, DOB, waiver type, CM core functions (10</td></tr></table></td><td>17th Not Met

19th Not Met</td></tr>
</table>

<table>
<tr><th>Compliance Indicator</th><th>Facts</th><th>Analysis</th><th>Conclusion</th></tr>
<tr><td></td><td></td><td>
<table>
<tr><td></td><td></td><td>elements), 65 other questions</td></tr>
<tr><td>Individualized goals</td><td>(blank)</td><td>(blank)</td></tr>
<tr><td>Self-direction of services</td><td>(blank)</td><td>(blank)</td></tr>
</table>
</td><td></td></tr>
<tr><td>37.18: The Community Inclusion/Integrated Settings KPA workgroup will develop, initiate, and monitor performance measures with a set target. Measures may be selected from, but not limited to, any of the following data sets: Employment; Community Engagement/Inclusion; QSRs; NCI – (i.e., Individual Outcomes); WaMS</td><td>The CII KPA workgroup and the CMSC developed and initiated performance measures for “choice and self-determination.”

Each included a set target, or goal.

DBHDS assigned the CII KPA workgroup or the CMSC to monitor each performance measure.

Based on a review of meeting minutes DBHDS submitted, the CII KPA and CMSC respectively monitored each of the assigned performance measures.

Based on the findings for CI 36.01 and CI 38.01, the Office of DQV had</td><td>As referenced in the corresponding chart for CI 36.01 above, the CII KPA workgroup and the CMSC developed and initiated performance measures for “choice and self-determination.” Each included a set target, or goal, and DBHDS assigned either the CII KPA workgroup or the CMSC to monitor each performance measure. In addition, based on a review of meeting minutes DBHDS submitted, CII KPA workgroup and the CMSC respectively monitored each of the assigned performance measures.

However, based on the findings for CI 36.01 and CI 38.01, the Office of DQV had not yet determined that the applicable data source systems and/or PMI data collection methodologies produced valid and reliable data, so the data cannot be used to support compliance findings.</td><td>17th Not Met

19th Met*</td></tr>
</table>

Compliance Indicator	Facts	Analysis	Conclusion
	not yet determined that the applicable data source systems and/or PMI data collection methodologies produced valid and reliable data, so the data cannot be used to support compliance findings.		

<table>
<tr><th>Compliance Indicator</th><th>Facts</th><th>Analysis</th><th>Conclusion</th></tr>
<tr><td>37.19: The Community Inclusion/Integrated Settings KPA workgroup will finalize surveillance data to be collected for “community inclusion,” at minimum including data related to participation in groups and community activities, such as shopping, entertainment, going out to eat, or religious activity.</td><td>The CII KPA workgroup proposed surveillance data to be collected for “community inclusion.” These addressed all of the minimum criteria for CI 37.19</td><td>As illustrated below, the CII KPA workgroup finalized surveillance data to be collected for “community inclusion,” including, but not limited to, data related to participation in groups and community activities, such as shopping, entertainment, going out to eat, or religious activity.
<table>
<tr><th>Type of Data</th><th>Required Surveillance Data Report for Review</th><th>Data Elements to Review</th></tr>
<tr><td>Participation in groups and community activities such as shopping, entertainment,going out to eat, religious activity</td><td>Annual NCI In Person Survey - Community Inclusion, Participation and Leisure</td><td>age, gender, race/ethnicity, type of residence, residentialdesignation</td></tr>
<tr><td>Integrated work opportunities</td><td>Integrated Employmentand Day Services Report</td><td>Employment Report: unique identifier, DOB, employment start date, type of employment, current wage per hour, typicalhours worked per week, and primary disability;
Integrated Day Services Report: number in group day,
authorizations for community engagement and coaching</td></tr>
<tr><td>Integrated living options</td><td>Integrated Residential Settings Report</td><td>Name, setting type, number of beds, CSB, authorization date</td></tr>
</table></td><td>17th Not Met

19th Met</td></tr>
<tr><td>37.20: The Community Inclusion/Integrated Settings KPA workgroup will develop, initiate, and monitor performance measures with a set target. Measures may be selected from, but not</td><td>The CII KPA workgroup and CMSC developed and initiated performance measures for “community inclusion.”

Each included a set target, or goal.</td><td>As referenced in the corresponding chart for CI 36.01 above, the CII KPA workgroup and the CMSC developed and initiated performance measures for “community inclusion.” Each included a set target, or goal and DBHDS assigned either the CII KPA workgroup or the CMSC to monitor each performance measure. In addition, based on a review of meeting minutes DBHDS submitted, the CII KPA workgroup and CMSC respectively monitored each of the assigned performance measures</td><td>17th Not Met

19th Met*</td></tr>
</table>

Compliance Indicator	Facts	Analysis	Conclusion
limited to, any of the following data sets: Employment; Community Engagement/Inclusion; QSRs; Housing; Regional Support Teams; Home and Community-Based Settings; NCI – (i.e., Individual Outcomes); WaMS	DBHDS assigned the CII KPA workgroup and CMSC to monitor each performance measure. Based on a review of meeting minutes DBHDS submitted, the CII KPA workgroup and CMSC respectively monitored each of the assigned performance measures. Based on the findings for CI 36.01 and CI 38.01, the Office of DQV had not yet determined that the applicable data source systems and/or PMI data collection methodologies produced valid and reliable data, so the data cannot be used to support compliance findings.	However, based on the findings for CI 36.01 and CI 38.01, the Office of DQV had not yet determined that the applicable data source systems and/or PMI data collection methodologies produced valid and reliable data, so the data cannot be used to support compliance findings.	

<table>
<tr><th>Compliance Indicator</th><th>Facts</th><th>Analysis</th><th>Conclusion</th></tr>
<tr>
<td>37.21: The Provider Competency and Capacity KPA workgroup will finalize surveillance data to be collected for “access to services,” at minimum including: a. For individuals on the waitlist, length of time on the waitlist and priority level, as well as whether crisis services, Individual and Family Support Program funding, or a housing voucher have been received b. Ability to access transportation c. Provision of adaptive equipment for individuals with an identified need d. Service availability across geographic areas e. Cultural and linguistic competency</td>
<td>The PCC KPA finalized surveillance data to be collected for “community inclusion.” These addressed all of the minimum criteria for CI 37.21</td>
<td>As illustrated below, the PCC KPA workgroup finalized surveillance data to be collected for “access to services,” including for each of the criteria for CI 37.21: a. For individuals on the waitlist, length of time on the waitlist and priority level, as well as whether crisis services, Individual and Family Support Program funding, or a housing voucher have been received; b. Ability to access transportation; c. Provision of adaptive equipment for individuals with an identified need; d. Service availability across geographic areas; and, e. Cultural and linguistic competency.
<table>
<tr><th>Type of Data</th><th>Required Surveillance Data Report for Review</th><th>Data Elements to Review</th></tr>
<tr><td>For individuals on the waitlist, length of time on the waitlist and priority level, as well as whether crisis services, IFSP funding, or a housing voucher have been received</td><td>DS HCBS Waivers dashboard report to start; will cross reference with Housing and IFSP funding</td><td>HCBS Waivers Dashboard - # on waitlist, priority level, annual waitlist contact, service authorization, (a) KY - Housing tracks those on the waitlist who receive live-in supports (b) IFSP - gender, geography, possible race, age, individual or family making request, resources individual connected to, services looking for</td></tr>
<tr><td>Ability to access transportation</td><td>DMAS Transportation data</td><td># Using transportation, # late arrival, # timely arrival, # complaints, by region</td></tr>
<tr><td>Provision of adaptive equipment for individuals with an identified need</td><td>Mobile Rehab data</td><td># Repairs completed, # of pieces of equipment repaired, # of safety assessments, # safety assessment identified immediate repair need, # custom adaptations; outcomes - # reduced risk of bodily injury, # reduced risk of infection transmission due toskin breakdown, # minor adjustments for comfort and ease of use</td></tr>
</table>
</td>
<td>17th Not Met

19th Met</td>
</tr>
</table>

<table>
<tr><th>Compliance Indicator</th><th>Facts</th><th>Analysis</th><th>Conclusion</th></tr>
<tr><td></td><td></td><td>
<table>
<tr><td>Service availability across geographic areas</td><td>Baseline Measurement Tool</td><td>Provider, service type, FIPS code,</td></tr>
<tr><td>Cultural and linguistic competency</td><td>Annual NCI In Person Survey - Rights and Respect, Demographics annual NCI Family Survey</td><td>(1) From In Person Survey Rights and Respect, possibly Table 15 Staff treat person with respect. From In Person Survey Demographics, Table 21 Preferred Means of Communication and Table 22 Primary Language. Can also look at disparities across race/ethnicity and responses. (2) From Family Survey, can look at Demographics of Family Member Receiving Services - Table 4 Race and ethnicity Table 7 Family member's preferred means of communication; Demographics of Respondents - Table 23 Language usually spoken at home; Information and Planning - Table Q3 Does your case manager/service coordinator respect your family's choices and opinions; Access & Delivery of Services & Supports Table Q21 Do support workers speak to you in a way you understand? Table Q22 Are services delivered in a way that is respectful of your family's culture?</td></tr>
</table>
</td><td></td></tr>
<tr><td>37.22: The Provider Competency and Capacity KPA workgroup will develop, initiate, and monitor performance measures with a set target. Measures may be selected from, but not limited to, any of the following data</td><td>The PCC KPA workgroup and CMSC developed and initiated performance measures for “choice and self-determination.”

Each included a set target, or goal.</td><td colspan="2">As referenced in the corresponding chart for CI 36.01 above, the PCC KPA workgroup and other DBHDS committees developed and initiated performance measures for “access to services.” Each included a set target, or goal and DBHDS assigned a specific KPA workgroup or other DBHDS to monitor each performance measure. In addition, based on a review of meeting minutes DBHDS submitted, the PCC KPA and CMRC respectively monitored each of the assigned performance measures.

However, based on the findings for CI 36.01 and CI 38.01, the Office of DQV had not yet determined that the applicable data source systems and/or PMI data</td><td>17th Not Met

19th Met*</td></tr>
</table>

Compliance Indicator	Facts	Analysis	Conclusion
sets: NCI – (i.e., System Performance); WaMS; Individual and Family Support Program (IFSP); Provider Data Summary; QSRs	DBHDS assigned a specific KPA workgroup or other DBHDS to monitor each performance measure. Based on a review of meeting minutes DBHDS submitted, the PCC KPA workgroup and CMSC respectively monitored each of the assigned performance measures. Based on the findings for CI 36.01 and CI 38.01, the Office of DQV had not yet determined that the applicable data source systems and/or PMI data collection methodologies produced valid and reliable data, so the data cannot be used to support compliance findings.	collection methodologies produced valid and reliable data, so the data cannot be used to support compliance findings.	

<table>
<tr><th>Compliance Indicator</th><th>Facts</th><th>Analysis</th><th>Conclusion</th></tr>
<tr>
<td>37.23: The Provider Competency and Capacity KPA workgroup will finalize surveillance data to be collected for “Provider capacity,” at minimum including: a. Staff receipt of competency-based training b. Demonstration of competency in core competencies c. Demonstration of competency in elements of service for the individuals they serve</td>
<td>The PCC KPA finalized surveillance data to be collected for “Provide capacity.” These addressed all of the minimum criteria for CI 37.23</td>
<td>As illustrated below, the Provider Competency and Capacity KPA workgroup finalized surveillance data to be collected for “provider capacity,” including data related to : a. Staff receipt of competency-based training b. Demonstration of competency in core competencies c. Demonstration of competency in elements of service for the individuals they serve.
<table>
<tr><th>Type of Data</th><th>Required Surveillance Data Report for Review</th><th>Data Elements to Review</th></tr>
<tr><td>Staff receipt of competency based training</td><td>Supervisory Orientation Training COVLC
CM Modules VCU</td><td>Supervisory Orientation Training - #completed
CM Modules - CSB, CM, CM type, date initiated & completed;</td></tr>
<tr><td>Demonstration of competency in core competencies</td><td>Annual QRT Report</td><td>DMAS-DBHDS QRT: #employee records/providers reviewed; % met requirements; # receiving DSP orientation training; #receiving competency. QMR reviews sampling of providers, looks at initial competencies and annual demonstration of competency.</td></tr>
<tr><td>Demonstration of competency in elementsof service for the individuals they serve</td><td>Annual QRT Report</td><td>DMAS-DBHDS QRT: #employee records/providers reviewed; % met requirements; # receiving DSP orientation training; #receiving competency. QMR reviews sampling of providers, looks at initial competencies and annual demonstration of competency.</td></tr>
<tr><td>Case Management Data</td><td>SCQR</td><td>CSB, name, sex, DOB, waiver type, CM core functions (10 elements), 65 other questions</td></tr>
</table>
</td>
<td>17th Not Met

19th Met</td>
</tr>
</table>

Compliance Indicator	Facts	Analysis	Conclusion
37.24: The Provider Competency and Capacity KPA workgroup will develop, initiate, and monitor performance measures with a set target. Measures may be selected from, but not limited to, any of the following data sets: Staff competencies; Staff training; QSRs; Provider Data Summary; QMRs; Licensing Citations	The PCC KPA workgroup and the CMSC finalized surveillance data to be collected for "community inclusion," including, but not limited to, data related to participation in groups and community activities, such as shopping, entertainment, going out to eat, or religious activity. However, based on the findings for CI 36.01 and CI 38.01, the Office of DQV had not yet determined that the applicable data source systems produced valid and reliable data, so the data cannot be used to support compliance findings.	As referenced in the corresponding chart for CI 36.01 above, the PCC KPA workgroup and other DBHDS committees developed and initiated performance measures for "provider capacity." Each included a set target, or goal. DBHDS assigned the PCC KPA workgroup or CMSC to monitor each performance measure. In addition, based on a review of meeting minutes DBHDS submitted, the PCC KPA and CMSC respectively monitored each of the assigned performance measures However, based on the findings for CI 36.01 and CI 38.01, the Office of DQV had not yet determined that the applicable data source systems produced valid and reliable data, so the data cannot be used to support compliance findings.	17th Not Met 19th Met*

V.D.4 Analysis of 19th Review Period Findings

Section V.D.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.

Compliance Indicator	Facts	Analysis	Conclusion
38.01: The Commonwealth collects and analyzes data from the following sources: a. Computerized Human Rights Information System (CHRIS): Serious Incidents – Data related to serious incidents and deaths. B. CHRIS: Human Rights – Data related to abuse and neglect allegations. C. Office of Licensing Information System (OLIS) – Data related to DBHDS-licensed providers, including data collected pursuant to V.G.3, corrective actions, and provider quality improvement plans. D. Mortality Review e. Waiver Management System (WaMS) – Data related to individuals on the waivers, waitlist, and service authorizations. F. Case Management Quality	At the time of the 17th Period review, DBHDS continued to collect data from all of the designated sources, but based on its own internal self-assessments by the Office of DQV (i.e., the *Data Quality Plan Source Systems Assessments: Findings and Recommendations* December 2019 and *Data Quality Plan Source Systems Assessments: Findings and Recommendations from an agency perspective*, January 2020), questions with regard to the reliability of the data remained, including data quality concerns related to system architecture and the status of development of data provenance documentation. For this review, DBHDS submitted a *Data Quality*	The single compliance indicator for this provision requires the Commonwealth to collect and analyze data from 13 source systems, at a minimum. The previous review examined the progress DBHDS had made in the areas of collecting and analyzing data from a set of prescribed sources. At that time, it appeared that DBHDS continued to collect data from all of these sources, but based on its own internal self-assessments by the Office of DQV (i.e., the *Data Quality Plan Source Systems Assessments: Findings and Recommendations* December 2019 and *Data Quality Plan Source Systems Assessments: Findings and Recommendations from an agency perspective*, January 2020), questions with regard to the reliability of the data remained. In particular, those questions related to 1) the data quality concerns related to system architecture, as identified in the respective source system assessments, and 2) the status of development of data provenance documentation. Based on the documentation provided for this review, as described with regard to CI 36.01, as well as interviews with key staff, DBHDS had not yet fully addressed the findings and recommendations of those self-assessments. While *Data Quality Monitoring Plan Source System Annual Update,* dated June 2021, outlined some steps taken to improve data quality in eight of the previously-studied source systems, DBHDS did not assert that any of the source systems produced valid and reliable data. That said, as context, this study summarizes the previously identified findings related to concerns for each of the 13 source systems, as well as any improvements described in the Annual Update of June 2021. Of note, due to the significant delay by DBHDS in providing this document for review, this study could not complete any independent examination of the implementation of the improvements listed therein and cannot validate these assertions.	17th Not Met 19th Not Met

Compliance Indicator	Facts	Analysis	Conclusion
Record Review – Data related to service plans for individuals receiving waiver services, including data collected pursuant to V.F.4 on the number, type, and frequency of case manager contacts. G. Regional Education Assessment Crisis Services Habilitation (REACH) – Data related to the crisis system. H. Quality Service Reviews (QSRs) i. Regional Support Teams j. Post Move Monitoring Look Behind Data k. Provider-reported data about their risk management systems and QI programs, including data collected pursuant to V.E.2 l. National Core Indicators m. Training Center reports of allegations of abuse, neglect, and serious incidents	*Monitoring Plan Source System Annual Update,* dated June 2021, stated that that the recommendations from the original version of the Data Quality Monitoring Plan, dated Fall 2019, and accompanying source systems assessments have not yet been addressed and further concluded that additional efforts are needed to sufficiently address data quality as outlined in the original report. The *Data Quality Monitoring Plan Source System Annual Update* also outlined some steps taken to improve data quality in eight of the previously-studied source systems, but did not assert that any of the source systems produced valid and reliable data. Due to the significant delay by DBHDS in providing documents for review, this study could not complete any independent examination of the implementation of	a. Computerized Human Rights Information System (CHRIS): Serious Incidents - Data related to serious incidents and deaths: Previously reported limitations with regard to the CHRIS architecture and processes included the following: • A confusing and incomplete protocol of checkboxes with regard to type of incident had resulted in the majority of incidents being coded as "other." There had been some improvement with regard to the percentage of incidents being coded as "other," but additional work continued to be needed. • Information about how and why incidents occurred was still sometimes recorded in free-text boxes, which did not make aggregation for analysis feasible. • A provider address drop-down menu could include thousands of locations, including closed locations, and these options are not listed in alphabetical or numeric order. As a result, addresses were often incorrect; • When an injury occurs as the result of abuse, the CHRIS architecture requires providers to enter a report twice, once in the licensing database and once in the OHR side of the system. This increased the likelihood of error and conflicting information; and, • Lack of a unique identifier for individuals in the system, making it difficult to match records within CHRIS and externally for identifying potential individual trends. For the 19th Period review, the *Data Quality Monitoring Plan Source System Annual Update* noted the following data quality improvements, which are yet to be verified: • The Office of Licensing (OL) updated system training documents for CHRIS-SIR, including instructions for how to get approved users in Delta and the CHRIS-SIR navigation guide. • CHRIS-SIR implemented the use of required fields and added format controls for all date fields within the system.	

Compliance Indicator	Facts	Analysis	Conclusion
	the improvements listed therein and cannot validate the assertions or the extent to which they might have sufficiently ameliorated the previously-identified concerns/deficiencies.	• One significant change to the CHRIS User Interface that impacts both CHRIS-SIR and CHRIS-HR prevents CHRIS from opening a previously viewed record when the web application is launched, a problem that previously resulted in some data being overwritten by mistake. • The Business Owner and SME of CHRIS-SIR began issuing monthly updates to users about common data entry errors, data highlights, and system alerts. OL has also revised the CHRIS-SIR training process and has begun uploading training videos to their website. • The system is pending replacement. b. CHRIS: Human Rights - Data related to abuse and neglect allegations: Numerous data quality issues existed within the architecture, and it lacked advanced business rule to prevent erroneous data entry. It also allowed for the creation of multiple profiles for the same person and multiple records for the same incident. For the 19th Period review, the *Data Quality Monitoring Plan Source System Annual Update* noted the following data quality improvements, which are yet to be verified: • The aforementioned change to the CHRIS User Interface that prevents CHRIS from opening a previously viewed record when the web application is launched. • The Office of Human Rights (OHR) updated training documentation related to CHRIS, Quick Reference Guides, and the CHRIS-HR User Navigation Guide. • OHR updated the DBHDS Advocate Report section within CHRIS-HR to reflect several new actions that an advocate can take during a provider's investigation. • OHR revised the training process for CHRIS-HR, so that providers are now scheduled for training by OHR Advocates, rather than selecting their own training dates.	

Compliance Indicator	Facts	Analysis	Conclusion
		• The Business Owner of CHRIS-HR has also taken a more proactive approach by distributing memos about system issues or updates. • The system is pending replacement. c. Office of Licensing Information System (OLIS)–Data related to DBHDS-licensed providers, including data collected pursuant to V.G.3, corrective actions, and provider quality improvement plans: Numerous concerns existed with the architecture and functionality of the system, including system instability and cumbersome user interfaces that at times caused users to rely on manual and informal strategies. Further, the processes used to monitor compliance with regulations appeared to vary substantially among licensing specialists. For the 19th Period review, the *Data Quality Monitoring Plan Source System Annual Update* noted that OL is finalizing the development of CONNECT, a new system which is expected to replace OLIS in fall of 2021. In addition, the following data quality improvements, which are yet to be verified, were noted: • OL updated and produced a variety of internal training materials for OLIS to improve the reliability of data entered into the system, including internal standard operating procedures and how-to guides. • OL revised their training process for OLIS so that new users are paired with OL Specialists for a detailed walkthrough of the system. d. Mortality Review - According to that study, this Microsoft Access database were limited data validation features, quality concerns regarding the loading of data from various external data sources and unlocked fields that could be overwritten with no audit trail to show who made the changes or when they occurred. This also presented opportunities for conflicting data	

Compliance Indicator	Facts	Analysis	Conclusion
		to exist between the Mortality Review Form and the original source system. For the 19th Period review, the *Data Quality Monitoring Plan Source System Annual Update* noted the following data quality improvements, which are yet to be verified: • The Electronic Mortality Review Form (eMRF) implemented a change log that documents every change to form since its creation in September 2019. • The eMRF developer created user interaction diagrams and developer documentation that stores all new code implemented in the source system. • The eMRF received a complete re-build of the front-end user interface; adding display logic, conditional visibility of certain fields, a workflow status flag that helps users identify when records can be edited, an advanced search feature that allows users to identify the correct records, and a report through which users can review all data in the record at any time during the data entry process. These updates may help reduce the frequency of data entry errors. • In addition to numerous data validation controls, a system-initiated "completeness check" was added to the eMRF that ensures all data are entered before records can be submitted. • The system is pending replacement. e. Waiver Management System (WaMS) - Data related to individuals on the waivers, waitlist, and service authorizations: Due to WaMS interfaces with a variety of other vendor supported systems, including the various electronic health records at CSBs, the insufficient data controls in those external systems were also likely to impact data quality in WaMS. The study also recommended that assessing the data validation controls on that imported data should be a next priority. There were also some gaps in data provenance documentation.	

Compliance Indicator	Facts	Analysis	Conclusion
		For the 19th Period review, the *Data Quality Monitoring Plan Source System Annual Update* noted the following data quality improvements, which are yet to be verified: • The WaMS team produced standard operating procedures for processes performed by their statistician, as well as guidance documents for new modules. • WaMS received an enhanced search functionality for "My List", a tool that allows users to identify which ISPs are due to be updated, and an update to the user interface that allows the system to accommodate multiple open modules within a reduced-size window without losing access to unsaved modules. These changes to WaMS will help ensure that ISP data are updated within a timely manner, and can help prevent users from being required to re-enter data that could not be accessed in the reduced size windows. f. Case Management Quality Record Review - Data related to service plans for individuals receiving waiver services, including data collected pursuant to V.F.4 on the number, type, and frequency of case manager contacts. At the time of the 17th Period review, most of the data collection functionality for case management was in the process of migrating to WaMS, with the integration of the ISP into that system, but some data quality concerns persisted, such as continued reliance on CCS3 for some data collection The Office of DQV did not complete a source system assessment for CCS3, but previous reports of the Independent Reviewer documented related data reliability issues. For the 19th Period review, the *Data Quality Monitoring Plan Source System Annual Update* did not note any data quality improvements. g. Regional Education Assessment Crisis Services Habilitation (REACH) - Data related to the crisis system: There were some advanced business rules, mechanisms for data validation and ample technical documentation,	

Compliance Indicator	Facts	Analysis	Conclusion
		but the biggest potential draw-back was a lack of test-user access to anyone in the DBHDS Central Office, including the designated business owner. As a result, DBHDS staff could not independently conduct reliability checks. Other data quality concerns included a lack of data validation features and manual quality controls and field calculations (e.g., bed utilization) that increased the risk of human error. In addition, at that time, REACH data loaded into the Data Warehouse did not meet business requirements related to timeliness and validity. For the 19th Period review, the *Data Quality Monitoring Plan Source System Annual Update* noted the following data quality improvements which are yet to be verified as having been implemented. • REACH saw the addition of mandatory fields, check-boxes, and new classifications to dropdown menus to improve the accuracy of the data entered into the system. • The system is pending replacement. h. Quality Service Reviews (QSRs): At the time of the 17th Review Period, the Office of DQV had not completed a related source system assessment. For this 19th Period review, in response to a document request from the Independent Reviewer, DBHDS did not provide any documentation to show it had completed a review of data reliability for this source system. i. Regional Support Teams: Overall, the reliability of data collection and data reporting for this source system stemmed from the significant manual work. The Office of DQV noted that automation was required for achievement of compliance with the related Provision III.D.6, and that, further, DBHDS planned to achieve this through integration into WaMS. Based on documentation provided and interview, there were no new updates at the time of the 17th Period review. For the 19th Period review, the *Data Quality Monitoring Plan Source System Annual Update* noted the following data quality improvements which are yet to be verified:	

Compliance Indicator	Facts	Analysis	Conclusion
		• The Office of Provider Development produced the "Internal Process Guide", which documents the complete life-cycle of RST data. • The RST spreadsheet added data validation controls to their workbook, including dropdown menus and a data migration process to automatically populate data tables. j. Post Move Monitoring Look Behind Data: DBHDS had not completed any analysis of the reliability of data collected with regard to Post-Move Monitoring. The Office of DQV had specifically excluded this data source Post-Move Monitoring because DBHDS was no longer planning to use the existing spreadsheet. The *Data Quality Monitoring Plan Source System Annual Update* did not note any data quality improvements or updates. k. Provider-reported data about their risk management systems and QI programs, including data collected pursuant to V.E.2 - Based on the documentation provided (e.g., KPA measure methodologies) at the time of the 17th Period review, it appeared that, for the PMIs and for the pending risk measures, DBHDS staff pull and report aggregate data from various sources, including some for which the Office of DQV has documented data quality concerns (e.g., CHRIS, WaMs, CCS3 etc.) DBHDS did not provide evidence of a process whereby providers would report their own data specific to their risk management and quality management programs. This remained true for the 19th Period review as well. l. National Core Indicators: For both the 17th and 19th Period reviews, DBHDS continued to contract with the NCI vendor and Virginia Commonwealth University to complete the NCI survey process and to provide aggregate data. This process is entirely external to DBHDS and has a lengthy track record of consistent implementation and documentation of data provenance. NCI measures have also been recently approved by CMS for use in HCBS waiver programs. It would appear these data could be considered reliable.	

Compliance Indicator	Facts	Analysis	Conclusion
		m. Training Center reports of allegations of abuse, neglect, and serious incidents: Training Center staff used the CHRIS-HR system to report allegations of abuse and neglect and the PAIRS system for reporting of injuries and death. Some of the reported data quality issues included a lack of advanced validation or business rules to prevent erroneous data from being entered, a lack of updated and comprehensive systems documentation, including no comprehensive user manual from DBHDS Central Office, leaving each facility to interpret procedures and definitions in its own way, and a lack of training for all staff entering the data in the system. At the time of the Phase 1 report, the PAIRS system was being revamped and built into a web-based platform, with recommendations included the production of comprehensive documentation for users, a data dictionary and data definitions for the documentation library. For the 19th Period review, the *Data Quality Monitoring Plan Source System Annual Update* did not note any data quality improvements for PAIRS. However, the CHRIS system is pending replacement.	

V.D.5 Analysis of 19th Review Period Findings

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

Compliance Indicator	Facts	Analysis	Conclusion
39.01: The metrics listed for all portions of V.D.5 are predicated on the continued compliance of V.D.5.a for each RQC: "The councils shall	The RQC charter, updated as of December 2020, required that RQC membership included individuals experienced in data analysis, residential and	As described below with regard to CI 40.01, the RQC charter, updated as of December 2020, required that RQC membership included individuals experienced in data analysis, residential and other providers, CSBs, individuals receiving services, and families, and may include other relevant stakeholders. In addition, based on the *Master RQC Attendance FY2021* Updated 6.15.21, each RQC met these criteria.	17th Undetermined 19th Met

Compliance Indicator	Facts	Analysis	Conclusion
include individuals experienced in data analysis, residential and other providers, CSBs, individuals receiving services, and families, and may include other relevant stakeholders."	other providers, CSBs, individuals receiving services, and families, and may include other relevant stakeholders. In addition, based on the *Master RQC Attendance FY2021* Updated 6.15.21, each RQC met these criteria.		
39.02: DBHDS has a charter for Regional Quality Councils ("RQCs") that describes the standard operating procedures as described in indicator V.B.4.d. DBHDS orients at least 86% of RQC members based on the charter and on quality improvement, data analysis, and related practices.	The Regional Quality Council Charter was revised and re-published in December 2020. The RQC Charter stated that each member, including alternates, shall be oriented to the purpose, operations and member responsibilities. DBHDS provided documentation to show it provided, through a contract with the Partnership for People with Disabilities at the Virginia Commonwealth University (VCU), in concert with VCU's Project Living Well grant, orientation and additional training to the membership on quality improvement, data analysis, and related practices. The documentation provided showed that DBHDS	The Regional Quality Council Charter was revised and re-published in December 2020. As reported at the time of the 17th Period review, the updated charter contained all elements outlined in Indicator V.B.4.d including: • The charge to the committee (Statement of Purpose) • The chair of the committee (Leadership and Responsibilities) • The membership of the committee (Membership) • The responsibilities of the chair and members (Leadership and Responsibilities) • The frequency of activities of the committee (Meeting Frequency) • Committee quorum (Quorum) • Periodic review and analysis of reliable data to identify trends and system-level factors related to committee-specific objectives and reporting to the Quality Improvement Committee (Leadership and Responsibilities) At the time of the 17th Period review, the charter did not contain information about the structure and delivery of required training for RQC members and alternates. For this 19th Period review addressed the provision of orientation, stating the following: "Each member, including alternates, shall be oriented to the purpose, operations and member responsibilities. This orientation is completed independently online or virtually/live with a QI Specialist. This training shall be offered and suggested to be completed within one month of receiving notification of approval of membership. All RQC members, including alternates, shall be provided with slides from previous trainings	17th Met 19th Met

Compliance Indicator	Facts	Analysis	Conclusion
	oriented at least 86% of RQC members.	on quality improvement tools and methods and are asked to watch any related videos." In addition, for this review, DBHDS provided documentation to show it provided orientation to the membership on quality improvement, data analysis, and related practices. The orientation is provided through contract by the Partnership for People with Disabilities at the Virginia Commonwealth University (VCU), in concert with VCU's *Project Living Well* grant. The RQC Orientation is available on-line and is required for 100% of members and alternates. The orientation module provides a general overview of the RQCs and includes the purpose of RQCs, expectations of council participants, the structure of the state quality improvement committee and quality management programs at the DBHDS, key performance areas to be addressed by DBHDS, and tools that council members may use to assist in reviewing data and identifying needs. Documentation also indicated that the *Project Living Well* website (https://livingwell.partnership.vcu.edu/) offers additional training modules for RQC members, including the following: 1. Virginia Regional Quality Council Orientation 2. Operating Highly Effective Teams 3. Supporting People with Disabilities and Family Members as Essential Partners in Quality Improvement 4. Identifying and Understanding DD Data/Priorities of Your Community 5. Quality Improvement Tools and Methods On 8/11/21, DBHDS also sponsored a full day RQC Summit that provided additional training for members on the uses and applications of data. These were all very positive practices. In addition, DBHDS provided documentation to show DBHDS oriented at least 86% of RQC members. Based on a document entitled *Final RQC Membership and Orientation Process Flow*, the completion of orientation was a requirement for all RQC members and alternates, consistent with the RQC Charter and the Office of Community	

Compliance Indicator	Facts	Analysis	Conclusion
		Quality Improvement (OCQI) tracked completion for all members. DBHDS provided two additional documents, including a *Master RQC Attendance FY2021* updated 6/15/21 and a *Monitoring Questionnaire for Data Verification RQC Training Log Source System*, dated 8/27/21. The latter document relied solely on the former document as the data source, although the *Master RQC Attendance FY2021* provided for review did not document the completion of orientation. However, DBHDS provided another document entitled *RQC Orientation Data FY21Q4*, dated 6/22/21 to show that OCQI tracked completion of orientation. Based on this documentation, the RQCs achieved 86% of voting members completing orientation as required. In the first quarter of FY21, when the alternates were also included in the calculation, the percentage of orientation achieved for RQC 5 dipped to 85%, but the other four RQCs remained above 86%. In many instances, the RQCs achieved 100% completion. Of note, it was also positive to see that that the OCQI also provided a chart that highlighted the improvement in the provision of orientation and tracking of training across all members and alternates, including the significant improvement that occurred when they began to offer an additional live orientation.	
39.03 Each DBHDS Region has convened a RQC that serves as a subcommittee to the QIC as described in indicator V.B.4.	Each of the five regions has convened regular quarterly meetings of their appointed RQC. Per its charter, the RQCs serve as subcommittees to the QIC.	Consistent with the 17th Period finding, each of the five regions has convened regular quarterly meetings of their appointed RQC. Minutes were provided for quarterly meetings for the past four quarters. Per its charter, the RQCs serve as subcommittees to the QIC. Based on interview with the Director of Community Quality Improvement, a non-DBHDS RQC member (i.e., from one of the stakeholder membership groups), is appointed as a liaison to the QIC and participates in QIC meetings, in person or remotely. According to the RQC Orientation referenced above with regard to CI 39.02, this member is responsible for attending QIC meetings to report regional recommendations and findings and regional feedback on quality improvement initiatives. The RQC also designates an alternate liaison to ensure ongoing representation at the QIC.	17th Met 19th Met
39.04: DBHDS prepares and presents relevant and	DBHDS staff members continued to organize the	At the time of the 17th Period review, the study found that the DBHDS staff members who are standing members of each RQC organized the agenda and	17th Not Met

Compliance Indicator	Facts	Analysis	Conclusion
reliable data to the RQCs which include comparisons with other internal or external data, as appropriate, as well as multiple years of data (as it becomes available).	agenda and the presentation of relevant data reports for review by the RQC members. The documentation for the third and fourth quarters (i.e., for the period of 1/1/21through 6/30/21) sometimes showed the RQCs were provided with comparisons of current data with that from previous quarters. However, this was not yet consistent. Based on the findings for CI 36.01 and CI 38.01, the Office of DQV had not yet determined that the applicable data source systems produced valid and reliable data, so the data cannot be used to support compliance findings.	presentation of relevant data reports for review by the RQC members. However, the preparation of data reports and presentation of data continues to be an evolving process with ongoing focused improvement efforts to increase the accuracy and validity of the data being presented. For this review, DBHDS staff members continued to organize the agenda and the presentation of relevant data reports for review by the RQC members. DBHDS provided meeting minutes and materials for four quarters for SFY 21. The documentation for the third and fourth quarters (i.e., for the period of 1/1/21through 6/30/21) showed significant improvement over the first two quarters, in terms of specific data provided for review and the relevance to the roles and responsibilities of the RQCs as defined in their charters. In addition, the minutes sometimes showed the RQCs were provided with comparisons of current data with that from previous quarters. For example, it was positive that, for both the third and fourth quarters, the RMRC presentation to the RQCs consistently provided data for key topics (e.g., serious injuries) over multiple quarters. This allowed the RQC members to easily visualize trends over time and, as a result, formulate questions. However, this was not yet consistent. Examples included the following: • For both the third and fourth quarters, the MRC presentation to the RQCs provided only a little data with regard to the results of QIIs, which was usually embedded in the narrative rather than presented visually to facilitate member understanding. • The fourth quarter MRC presentation included a slide for the Sepsis QII that showed contributing factors to sepsis cases from case reviews for a period between 2018-2020, but was presented only in the aggregate for the three year period, rather than broken down so that RQC members could visualize the trends from year to year. • The third quarter KPA presentation to the RQCs included a slide entitled "Crisis Data" with a bar chart showing the percentage of crisis assessments completed in community settings for known persons, which ranged from 21% in Region 1 to 62% in Region 3. However, the chart did not indicate what period of time it covered, or break out the data to show whether the trend over time was positive or negative.	19th Not Met

Compliance Indicator	Facts	Analysis	Conclusion
		In addition, based on the findings for CI 36.01 and CI 38.01, the Office of DQV had not yet determined that the applicable data source systems produced valid and reliable data, so the data cannot be used to support compliance findings.	
39.05: Each RQC reviews and assesses (i.e., critically considers) the data that is presented to identify: a) possible trends; b) questions about the data; and c) any areas in need of quality improvement initiatives, and identifies and records themes in meeting minutes. RQCs may request data that may inform quality improvement initiatives and DBHDS will provide the data if available. If requested data is unavailable, RQCs may make recommendations for data collection to the QIC.	Consistent with the findings for CI 39.04, the documentation for the third and fourth quarters (i.e., for the period of 1/1/21through 6/30/21) showed significant improvement over the first two quarters of SFY 21. The minutes reflected discussion of possible trends and requests for additional data that might inform quality improvement initiatives. However, in many instances, the data presentations still did not provide data in a manner that facilitated the ability of the RQC members to visualize possible trends, and the RQC minutes did not yet consistently reflect that RQC members questioned the lack of these data. However, based on the findings for CI 36.01 and CI 38.01, the Office of DQV had not yet determined that the applicable data source systems produced valid and	At the time of the 17th Period review, the study found that RQC minutes reflected review and discussion of data presented about relevant service delivery processes, operational requirements, etc. The 17th study's conclusion that this indicator was Met did not consider that the data provided to the RQC's had not been determined to be reliable and valid. For this review, the RQC minutes provided continued to reflect that key DBHDS staff made data presentations and the minutes described captured good discussion, questions and requests for additional data. Consistent with the findings for CI 39.04 above, the documentation for the third and fourth quarters (i.e., for the period of 1/1/21through 6/30/21) showed significant improvement over the first two quarters. The minutes reflected discussion of possible trends and requests for additional data that might inform quality improvement initiatives. As one example of the latter, Region 1 RQC noted that their regional data for the timeliness of crisis referrals, when the compared with the other regions, appeared to be considerably lower, and asked DBHDS staff to look at the Region 1 data more closely to identify possible causes. DBHDS agreed to do so. However, as described above with regard to CI 39.04, in many instances, the data presentations still did not provide data in a manner that facilitated the ability of the RQC members to visualize possible trends, and the RQC minutes did not yet consistently reflect that RQC members questioned the lack of these data. In addition, based on the findings for CI 36.01 and CI 38.01, the Office of DQV had not yet determined that the applicable data source systems produced valid and reliable data, so the data cannot be used to support compliance findings.	17th Met 19th Not Met

Compliance Indicator	Facts	Analysis	Conclusion
	reliable data, so the data cannot be used to support compliance findings.		

Section V.D.5.b: Each council shall meet on a quarterly basis to share regional data, trends, and monitoring efforts and plan and recommend regional quality improvement initiatives. The work of the Regional Quality Councils shall be directed by a DBHDS quality improvement committee.

40.01: Each RQC meets quarterly with a quorum at least 3 of the 4 quarters with membership as outlined in the RQC charter. A quorum is defined as at least 60% of members or their alternates as defined in the RQC charter and must include representation from the following groups: the DBHDS QIC; an individual experienced in data analysis; a Developmental Disabilities (DD) service provider; and an individual receiving services or on the DD Waiver waitlist or a	Based on documentation submitted (i.e., Master RQC Attendance FY2021 Updated 6.15.21), each of the five RQCs achieved a quorum for all four quarters during SFY21, including representation from the required categories (i.e., the DBHDS QIC; an individual experienced in data analysis; a Developmental Disabilities service provider; and an individual receiving services or on the DD Waiver waitlist or a family member of an individual receiving services or on the DD Waiver waitlist.)	Consistent with the findings for the 17th Period review, for this review, each of the five regions within the Commonwealth had convened regular quarterly meetings of their appointed RQC. Minutes were provided for quarterly meetings for the past four quarters. The RQC charter, updated in December 2020, The RQC charter described the required membership representing the following stakeholder groups: • Residential Services Provider • Employment Services Provider • Day Services Provider • Community Services Board [CSB] Developmental Services Director • Support Coordinator/Case Manager • CSB Quality Assurance/Improvement staff • Provider Quality Assurance/Improvement staff • Crisis Services Provider • An individual receiving services or on the Developmental Disability Waiver waitlist [self-advocate] and/or a family member of an individual receiving services or on the waitlist. In addition, the charter required the appointment of an alternate for each of these members, representing the same stakeholder group as the member. The	17th Met 19th Met

family member of an individual receiving services or on the DD Waiver waitlist.		alternate for each membership role will serve as a proxy, including for voting, at meetings when the incumbent cannot attend. Alternates attend meetings in order to listen to discussion and decisions and receive meeting agendas, meeting minutes and reports to be considered at meetings. The charter indicated this would ensure continuity by providing the alternate with the ability to be informed in the event the member is not able to attend and the alternate is called upon to represent the stakeholder group. In addition to the representatives of stakeholder groups, three DBHDS staff members are standing members of each RQC. • Director of Community Quality Improvement • Regional Quality Improvement Specialist • Community Resources Consultant Based on documentation submitted (i.e., *Master RQC Attendance FY2021* Updated 6.15.21), each of the five RQCs achieved a quorum for all four quarters during SFY21, including representation from the required categories (i.e., the DBHDS QIC; an individual experienced in data analysis; a Developmental Disabilities service provider; and an individual receiving services or on the DD Waiver waitlist or a family member of an individual receiving services or on the DD Waiver waitlist.). DBHDS staff, interviewed indicated that participation of alternates had positively impacted the achievement of a quorum, among other positive benefits. As reported previously, the *Master RQC Attendance FY2021* reflected very few vacancies within the designated membership categories as well as consistent and active participation by most of the appointed members/alternates in each of the meetings. A family member representative was present in each of these meetings, but while most RQCs had an individual receiving services as a member, consistent participation for that stakeholder group remained sporadic. Region 2 has not had an individual receiving services as a member for the past year and continued to experience some challenge in recruiting for this representative.	
40.02: During meetings, conducted in accordance with its charter, the RQC	As of 3/26/21, all five RQCs had recommended and	At the time of the 17th Period review, each set of minutes of the RQC meetings reflected review of data, trends and monitoring efforts. They also included recommendations and follow-up from previous recommendations. Minutes	17th Not Met 19th Met*

reviews and evaluates data, trends, and monitoring efforts. Based on the topics and data reviewed, the RQC recommends at least one quality improvement initiative to the QIC annually.	implemented a QII for this review period. As described with regard to CI 39.04 and CI 39.05 above, the RQCs had improved their processes for reviewing and evaluating data, trends, and monitoring efforts and using those effort to recommend quality improvement initiatives to the QIC annually. Based on the findings for CI 36.01 and CI 38.01, the Office of DQV had not yet determined that the applicable data source systems produced valid and reliable data, so the data cannot be used to support compliance findings.	reflect at least one recommendation made to the QIC during the four quarters reviewed. The QIC returned each of the proposed initiatives with comments and instructions for improvement. The most commonly identified concern was the need to narrow the scope of the initiative to allow reasonable assurance that it could be implemented, and that data could be generated to measure its impact/effectiveness. As also reported previously, beginning in Spring 2020, DBHDS implemented a structure to guide the identification and development of a quality improvement initiative from each RQC. This process included specific training on the structure and methods to develop the initiative, a format for small-group review of data within each RQC, the selection of the topic area for the initiative, and the formulation of the content of the initiative to be submitted to the QIC for review and approval/disapproval. This structure was reported to have been a positive learning experience for RQC members interviewed and resulted in greater consistency in the content of the initiatives submitted for QIC review. This critical element of the responsibilities of the RQCs continues to be evolving and remains at a very early stage in development at this point in time. For this review, as described with regard to CI 39.04 and CI 39.05 above, it appeared the RQCs had taken a significant leap forward in their processes for reviewing and evaluating data, trends, and monitoring efforts and using those effort to recommend quality improvement initiatives to the QIC annually. Based on review of the minutes, the RQC recommended the following QIIs to the QIC: Region 1 RQC: By June 2022, increase provider capacity by 20% in Region 1 to offer In Home Support (IHS) to allow individuals the opportunity to live in the most integrated setting, appropriate to meet their needs. Date Implemented: 1/14/21 Region 2 RQC: By June 2022, prevent the rate of falls from returning to pre-COVID levels and "Maintain the Gain." Date Implemented: 3/26/21 Region 3 RQC: By June 2022, improve statewide DSP Competency completion rate by 30% (from 56% in SFY2019).	

		Date Implemented: 3/22/21 Region 4 RQC: Increase employment for persons aged 18-64 years old with DD Waiver Designation by improving understanding of how the various system aspects of employment work together to help persons with disabilities gain employment, resulting in an increase of 10% of persons in Region 4 having recorded employment outcomes in their plans. Date of Implementation: 2/17/21 Region 5 RQC: By June 2022, increase by 10% the number of individuals in Region 5 aged 18 64 who reported they have an employment outcome in data reported via CCS3 and/or WaMS for Region 5. Date of Implementation: 1/28/21 As described below with regard to CI 41.05, these QIIs had variable levels of measurability as written. In addition, based on the findings for CI 36.01 and CI 38.01, the Office of DQV had not yet determined that the applicable data source systems produced valid and reliable data, so the data cannot be used to support compliance findings.	
40.03: Each RQC maintains meeting minutes for 100% of meetings. Meeting minutes are reviewed and approved by the membership of the RQC to ensure accurate reflection of discussion and evaluation of data and recommendations of the RQC.	Each RQC maintained meeting minutes for 100% of meetings over the past four quarters. The minutes reflected that, at the beginning of each quarterly meeting, the membership of the RQC reviewed and approved the minutes from the previous meeting.	At the time of the 17th Period review, the study found that each of the five regions within the Commonwealth has convened regular quarterly meetings of their appointed RQC, with meeting minutes available for the previous four quarters. This remained true for this period as well. As also described in the study report from the 17th Period review, at the beginning of each quarterly meeting, the RQCs continued to review the content of the meeting minutes for the previous meeting and either approve it as submitted or identify needed revisions to accurately reflect the meeting discussions, requests and recommendations. Documentation of review and approval is noted in the minutes.	17th Met 19th Met
40.04: For each topic area identified by the RQC, the RQC a) decides whether more information/data is	The RQC minutes showed sustained compliance. The meeting agenda and minutes were structured to document the RQC's determination in	At the time of the 17th Period review, the study found that minutes of each of the applicable meetings reflected compliance with these requirements. For this review, the RQC minutes again showed sustained compliance. The meeting agenda and minutes were structured to document the RQC's determination in each of the topic areas they review, and each RQC adhered to and completed	17th Met 19th Met

needed for the topic area, b) prioritizes a quality improvement initiative for the Region and/or recommends a quality improvement initiative to DBHDS, or c) determines that no action will be taken in that area.	each of the topic areas they review, and each RQC adhered to and completed the template.	the template. As described with regard to CI 39.04 and CI 39.05 above, it appeared the RQCs had taken a significant leap forward in their processes for reviewing and evaluating data, trends, and monitoring efforts and using those effort to recommend quality improvement initiatives to the QIC annually.	
40.05: For each quality improvement initiative recommended by the RQC, at least one measurable outcome will be proposed by the RQC.	Overall, the outcomes for each QII had some level of measurability, but based on the information provided for review, none were sufficiently measurable. In addition, and also based on the information provided for review, it appeared that all of the outcomes would tap data sources currently in use at DBHDS. As noted throughout this report, based on the findings for CI 36.01 and CI 38.01, the Office of DQV had not yet determined that the applicable data source systems produced valid and reliable data, so the data cannot be used to support compliance findings.	At the time of the 17th Period review, the study confirmed the development of at least one measurable outcome and specification of data to be used in measurement of that outcome. However, the 17th conclusion did not consider whether the outcomes were written in sufficiently measurable terms, For this review period, the study found that, generally speaking, the name of the QII was also the proposed outcome. Overall, the outcomes had some level of measurability, but none were sufficiently measurable based on the information provided for review. For example, it was positive that four of the five QIIs set a target date for completion. It was also positive that each RQC specified a percentage improvement they hoped to achieve, but only one provided a baseline metric from which the increase should be measured. DBHDS plans indicate that they have adopted the Plan-Do-Study-Act (PDSA) quality improvement strategy and the use of SMART (Specific Measurable Attainable Relevant) goals, but the lack of measurable goals has been identified in many areas of Virginia's service system, including, but not limited to. the goals developed by the RQC's. Committing to create SMART goals is good, but the SMART template provided only one criterion for measurability, that is "to define what evidence will prove you're making progress and reevaluate when necessary." The facts gathered regarding the RQCs indicate that this single criterion has not been sufficient to ensure the creation of measurable RQC goals and the need for additional criteria and monitoring. The deficits in measurability are described above and below. Going forward, the RQCs should fully document the criteria for measurability, to the extent feasible. If the extent of improvement actually achieved cannot be determined, the outcome is not sufficiently measurable. As DBHDS implements	17th Met 19th Not Met

		the next steps in the Data Quality Monitoring Plan (i.e., as described with regard to CI 36.06 above), that should also move closer to meeting this CI. As detailed in the 18th Period review for CI 29.10, the RQCs might wish to consider the following guidance for development of measurable QIIs. • As with any planning document, some preliminary work is needed to determine the scope and potential causes of the problem, and then to develop a set of targeted and measurable interventions. These interventions, or action steps should form a methodical path that begins at the baseline and ends with achievement of the goal, with clear mechanisms for measuring progress along the way. This often requires some additional preliminary work before embarking on the design and implementation of the QII action steps. • To lend itself to ongoing measurement and evaluation, the QII should define an anticipated outcome of each action step. In general, the anticipated outcome of each action step should allow DBHDS staff to assess the interim success of that step on the path toward the overall goal of the QII. It is also important to clearly state the anticipated outcome of each action step in a measurable way. In order to develop a measurable interim outcome for an action step, it is necessary to have conceptualized and defined why one thinks the action step will make a difference, and therefore, help to achieve the overall goal. • The QII should include a time frame in which each action step must occur: Each of the action steps should reference both expected implementation/initiation and completion dates. The reasons for providing a timeline are not only to project implementation and achievement dates, but also to serve as a benchmark for review and modification when implementation or achievement are not reached as planned. In other words, the timelines, among other aspects of the CAP , should be monitored and revised as needed, based on the results (i.e., relevant data). The QIIs also typically focused on the source of data collection related to the selected strategy and did not specify the data source for the desired outcome. The exception was the QII for the Region 5 RQC, which specified the outcome data sources would be CCS3 and WaMS. It appeared that the other outcomes	

		would also tap data sources currently in use at DBHDS. As noted throughout this report, based on the findings for CI 36.01 and CI 38.01, the Office of DQV had not yet determined that the applicable data source systems produced valid and reliable data, so the data cannot be used to support compliance findings.	
40.06: 100% of recommendations agreed upon by the RQCs are presented to the DBHDS QIC.	Based on review of the available RQC and QIC minutes, 100% of recommendations agreed upon by the RQCs are presented to the DBHDS QIC.	Based on review of the available RQC and QIC minutes, 100% of recommendations agreed upon by the RQCs are presented to the DBHDS QIC. DBHDS provided one set of QIC minutes for review, dated June 28, 2021. This study examined the SFY 21 fourth quarter minutes for each RQC to identify any recommendations for the QIC, as well as the QIC minutes for June 28, 2021 to determine if the recommendation was presented. Based on the review of the QIC minutes for June 28, 2021, those minutes reports that each RQC reported any recommendations for the QIC regarding systemic improvement. The QIC minutes documented the following recommendations and related QIC actions: • RQC 1 recommended that DBHDS "capture data" around Medicaid transportation timeliness or excessive wait times to explore how this might impact health outcomes for folks reliant on this service. QIC Action Step: RQC1 Recommendation: A DMAS representative will relay the question back to DMAS on behalf of the QIC and will also provide an update to DMAS' response at the next meeting. • RQC5 recommended increasing the number of dental providers that accept Medicaid. QIC Action Step: The QIC determine no action was needed as the adult dental benefit for Medicaid begins July 1 and the KPA Workgroups is proposing a QII around this topic. This appeared to accurately reflect the RQC recommendations for the QIC.	17th Met 19th Met
40.07: The DBHDS QIC reviews the recommendations reported by the RQCs and directs the	Based on the single set of QIC minutes DBHDS provided for review, it appeared the QIC had	At the time of the 17th Period review, the study found that the process for QII development by the RQCs was in its initial development. While each of the RQCs had drafted an initiative and submitted it to the QIC for review, the QIC had not approved any of the initial submissions and returned each to the respective RQC with comments and suggestions for further work.	17th Not Met 19th Not Met

implementation of any quality improvement initiatives upon approval by the QIC and the Commissioner. Relevant Department staff may be assigned to statewide quality improvement initiatives to facilitate implementation. The QIC directs the RQC to monitor the regional status of any statewide quality improvement initiatives implemented and report annually to the DBHDS QIC on the current status. The DBHDS QIC reports back to each RQC at least once per year on any decisions and related implementation of RQC recommendations. If the QIC declines to support a quality improvement initiative recommended by a RQC, the QIC shall document why.	reviewed and approved a QII for each RQC. Based on review of the fourth quarter Regional Quality Councils Report to the QIC, dated June 28, 2021, all five RQCs reported on the status of their QIIs. Due to the limited documentation provided for review, it was unknown if the QIC had declined to support any QIIs during this past year or made reports back to each RQC at least once per year on any decisions and related implementation of RQC recommendations, so compliance cannot be confirmed.	For this review, and based on the QIC minutes DBHDS provided for review, the QIC had reviewed and approved a QII for each RQC, as described above with regard to CI 40.02. Due to the limited documentation available, it was unknown if the QIC had declined to support any QIIs during this past year or made reports back to each RQC at least once per year on any decisions and related implementation of RQC recommendations. Based on review of the fourth quarter Regional Quality Councils Report to the QIC, dated June 28, 2021, all five RQCs reported on the status of their QIIs. In addition, the Region 1 and Region 5 RQCs developed full presentations of the interim results of their QIIs to be provided at the QIC meeting on 9/27/21. Overall, these regional efforts appeared to be an impressive body of work. In interview with the Director of OCQI, he described the intensive and collaborative work among RQC members, Office of DQV staff and others to develop, implement and analyze the results of their strategies. For example, for the Region 5 QIC (i.e., increase by 10% the number of individuals in Region 5 aged 18-64 who reported they have an employment outcome), the RQC developed a QII workgroup. The Director of OCQI reported the members of that workgroup focused on how to identify barriers to development of employment outcomes in ISPs and planned a survey to probe these barriers, targeted to support coordinators, who have the responsibility for facilitating the development of the ISP overall. In order to develop a meaningful survey tool and process, the members recruited support coordinators to serve on the work group and assist with brainstorming how best to probe and discover barriers. In addition, the workgroup tapped into the assistance of staff from the Office of DQV to help with constructing a valid survey process and in data analysis and presentation. The presentations provided for review of this effort (i.e., the *RQC5 Employment Outcomes QII Status Update September 27, 2021*, and the *RCQ5 Employment Outcome Survey Responses September 27, 2021*) demonstrated a well thought out, planned and implemented QII strategy that provided important data analysis for future progress. This was good to see and illustrated the overall maturation of the RQCs since the previous review.	

V.D.6 Analysis of 19th Review Period Findings

Section V.D.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 improvements.

Compliance Indicator	Facts	Analysis	Conclusion
41.01: The Commonwealth posts reports, updated at least annually, on the Library Website or the DBHDS website on the availability and quality of services in the community and gaps in services and makes recommendations for improvement. Reports shall include annual performance and trend data as well as strategies to address identified gaps in services and recommendations for improvement strategies as needed and the implementation of any such strategies.	In previous reviews, the Provider Development Summary has been the primary vehicle by which DBHDS reports on the availability and quality of services in the community and gaps in services and makes recommendations for improvement, as required by CI 41.01, but DBHDS did not provide an updated document for review during this review period. The Office of DQV published a *Data Quality Monitoring Plan Source System Annual Update*, dated June 2021, that outlined some steps taken to improve data quality in eight of the previously-studied source systems, but DBHDS did not assert that any of the	For this review, as described below with regard to CI 41.02, CI 41.03 and CI 4.04, upon review of the Library Website and DBHDS website, DBHDS did not provide an annually-updated report with regard to on the availability and quality of services in the community and gaps in services and makes recommendations for improvement, as outlined in CI 41.01. In previous reviews, the *Provider Development Summary* has been the primary vehicle by which DBHDS reported the data and recommendations required by CI 41.01, but DBHDS did not provide an updated document for review during this review period. As of 10/8/21, the most recent version available on the DBHDS Website, Provider Development webpage, provided a link to a *Provider Data Summary Semi-Annual Report State Fiscal Year 2020-2021,* covering a period from May 1, 2020 to October 31, 2020. The 17th Period review also noted that, based on the assessment the Office of DQV completed in Phase 3 of its Data Monitoring Plan, additional source system work was needed to ensure all the data reported were reliable. As described above with regard to CI 36.01 and CI 38.01, for this review period, while the Office of DQV published a *Data Quality Monitoring Plan Source System Annual Update,* dated June 2021, that outlined some steps taken to improve data quality in eight of the previously-studied source systems, DBHDS did not assert that any of the source systems produced valid and reliable data.	17th Not Met 19th Not Met

Compliance Indicator	Facts	Analysis	Conclusion
	source systems produced valid and reliable data. Therefore, the data cannot be used for compliance reporting.		
41.02: Demographics – Individuals served a. Number of individuals by waiver type b. Number of individuals by service type c. Number of individuals by region d. Number of individuals in each training center, Number of children and adults with DD who were admitted to, or residing in, state operated psychiatric facilities f. Number of children residing in NFs and ICFs/IIDs, g. Number of adults residing in ICFs/IIDs and NFs (to the extent known) h. Number of individuals with DD (waiver and non-waiver) receiving Supported Employment i. Number of individuals with DD receiving crisis services by type, by region and disposition j. Number of individuals on the DD waiver waiting list by	As described below with regard to CI 41.05, as of 10/15/21, DBHDS had not posted to the Library Website or the DBHDS website annually-updated reports. In previous reviews, the *Provider Development Summary* has been the primary vehicle by which DBHDS reports the demographic data required by CI 41.02, but DBHDS did not provide an updated document for review during this review period. The Office of DQV published a *Data Quality Monitoring Plan Source System Annual Update,* dated June 2021, that outlined some steps taken to improve data quality in eight of the previously-studied source systems, but DBHDS did not assert that any of the	For this review, as described below with regard to CI 41.02, CI 41.03 and CI 4.04, upon review of the Library Website and DBHDS website, DBHDS did not provide an annually-updated report with regard to the demographics outlined in CI 41.02. In previous reviews, the *Provider Development Summary* has been the primary vehicle by which DBHDS reports the demographic data required by CI 41.02, but DBHDS did not provide an updated document for review during this review period. As of 10/8/21, the most recent version available on the DBHDS Website, Provider Development webpage, provided a link to a *Provider Data Summary Semi-Annual Report State Fiscal Year 2020-2021,* covering a period from May 1, 2020 to October 31, 2020. The 17th Period review also noted that, based on the assessment the Office of DQV completed in Phase 3 of its Data Monitoring Plan, additional source system work was needed to ensure all the data reported were reliable. As described above with regard to CI 36.01 and CI 38.01, for this review period, while the Office of DQV published a *Data Quality Monitoring Plan Source System Annual Update,* dated June 2021, that outlined some steps taken to improve data quality in eight of the previously-studied source systems, but DBHDS did not assert that any of the source systems produced valid and reliable data. Therefore, the data cannot be used for compliance reporting.	17th Not Met 19th Not Met

Compliance Indicator	Facts	Analysis	Conclusion
priority level, geographic region, age, and amount of time that individuals have been on the waiting list. K. Number of individuals in independent housing.	source systems produced valid and reliable data. Therefore, the data cannot be used for compliance reporting.		
41.03: Demographics – Service capacity a. Number of licensed DD providers i. Residential setting by size and type as defined by the Integrated Residential Services Report ii. Day services by type as defined by the Integrated Day Services Report b. Number of providers of Supported Employment and Therapeutic Consultation for Behavioral Support Services Number of providers of non-licensed services (e.g., supported employment, crisis) c. Number of ICF/IID non-state operated beds d. Number of independent housing options created	As described below with regard to CI 41.05, as of 10/15/21, DBHDS had not posted to the Library Website or the DBHDS website annually-updated reports on the availability and quality of services in the community and gaps in services and makes recommendations for improvement. In previous reviews, the *Provider Development Summary* has been the primary vehicle by which DBHDS reports the demographic data required by CI 41.03, but DBHDS did not provide an updated document for review during this review period.	For this review, as described below with regard to CI 41.02, CI 41.03 and CI 4.04, upon review of the Library Website and DBHDS website, DBHDS did not provide an annually-updated report with regard to the demographics outlined in CI 41.03. In previous reviews, the *Provider Development Summary* has been the primary vehicle by which DBHDS reports the demographic data required by CI 41.03, but DBHDS did not provide an updated document for review during this review period. As of 10/8/21, the most recent version available on the DBHDS Website, Provider Development webpage, provided a link to a *Provider Data Summary Semi-Annual Report State Fiscal Year 2020-2021,* covering a period from May 1, 2020, to October 31, 2020. The 17th Period review also noted that, based on the assessment the Office of DQV completed in Phase 3 of its Data Monitoring Plan, additional source system work was needed to ensure all the data reported were reliable. As described above with regard to CI 36.01 and CI 38.01, for this review period, while the Office of DQV published a *Data Quality Monitoring Plan Source System Annual Update*, dated June 2021, that outlined some steps taken to improve data quality in eight of the previously-studied source systems, but DBHDS did not assert that any of the source systems produced valid and reliable data.	17th Not Met 19th Not Met

Compliance Indicator	Facts	Analysis	Conclusion
41.04: The DBHDS Annual Quality Management Report and Evaluation includes the following information: a. An analysis of Data Reports, including performance measure indicators employed, an assessment of positive and negative outcomes, and performance that differs materially from expectations b. Key Performance Areas performance measures with set targets: 1. Health, Safety, and Well Being 2. Community Inclusion– Integrated Settings 3. Provider Capacity and Competency c. Case Management Steering Committee Report, Risk Management Review Committee Report e. Annual Mortality Review Report, including Quality Improvement Initiatives stemming from mortality reviews f. Quality Management Program Evaluation g. Planned quality improvement initiatives metrics h.	DBHDS last issued an *Annual Quality Management Report and Evaluation* on 3/31/21 and was within 12 months of the previous report issued in May 2020. It included information for all the topics defined in the CI 43.04. However, based on the findings for CI 36.01 and CI 38.01, the Office of DQV had not yet determined that the applicable data source systems produced valid and reliable data, so the data relied upon for the issuance of *Quality Management Plan: Annual Report and Evaluation* cannot be used to support compliance findings.	For the 17th Period review, in May 2020, DBHDS had issued a *Quality Management Plan: Annual Report and Evaluation State Fiscal Year 2019.* As noted in the study report at that time, the data and information were nearly a year old and were not particularly useful in providing the public with a status report and do not lend itself to actionable quality improvement. During interviews at that time, to address these concerns, DBHDS staff reported they were in the process of adjusting the schedule for the production of the report. For this 19th Period review, DBHDS last issued an updated version of the document on 3/31/21 (i.e., *Quality Management Plan: Annual Report and Evaluation State Fiscal Year 2020.*) This most recent version again included information for all the topics defined in the compliance indicator. In terms of data recency, the *Quality Management Plan: Annual Report and Evaluation State Fiscal Year 2020* covered a period between 7/1/19 -6/30/20. This represented some improvement in the timeliness of the document production, but data were still approximately nine months old and again not particularly useful in providing the public with a status report or for actionable quality improvement. At the time of this 19th Period Review, by October 2021, DBHDS had not issued an annual update for SFY 21(i.e., for the period between 7/1/20 through 6/30/21, but DBHDS staff stated they anticipated publishing such an update by December 2021 or January 2022. This would represent a succeeding improvement in terms of data recency, which would be positive. However, based on the findings for CI 36.01 and CI 38.01, the Office of DQV had not yet determined that the applicable data source systems produced valid and reliable data, so the data relied upon issuance of *Quality Management Plan: Annual Report and Evaluation* cannot be used to support compliance findings.	17th Not Met 19th Not Met

Compliance Indicator	Facts	Analysis	Conclusion
Quality Improvement initiatives metrics employed i. Key Accomplishments of the Quality Management Program j. QI Committee, workgroup and council challenges, including positive and negative outcomes and/or performance measure indicators outcomes that differ materially from expectations. Challenges, including positive and negative outcomes and/or indications that performance is below expectations. K. Committee Performance l. A summary of areas reviewed by the Regional Quality Councils, along with recommendations and any strategies employed for quality improvement m. A summary of areas reviewed by the DBHDS Quality Improvement Committee (QIC), along with gaps identified, recommendations, and any strategies employed for quality improvement n. Recommendations and			

Compliance Indicator	Facts	Analysis	Conclusion
strategies for related improvement			
41.05: Additional information, including areas reviewed, and where available, gaps identified, recommendations, and strategies employed for quality improvement, and reports available: a. Results of licensing findings resulting from inspections and investigations b. Data Quality Plan c. Annual Quality Service Review d. Annual REACH Report on crisis system e. Semi-Annual Supported Employment Report f. RST Annual Report, including barriers to integrated services g. Semi-annual Provider Data Summary Report: provides information on geographic and population based disparities in service availability as well as barriers to services by region h. IFSP outcomes	For this review, DBHDS submitted a document entitled *DOJ Settlement Agreement Library Protocol*, dated June 30, 2020. As described above with regard to CI 41.01, the protocol described the requirements for maintaining and updating the Library site. It states that all documents must be reviewed and updated as necessary to ensure the Library includes all current documentation of the Commonwealth's compliance with the Settlement Agreement. Based on review of the documentation available the Library site and/or DBHDS website during this 19th Period review (i.e., as of 10/8/21), many of the designated reports for CI	For this review, DBHDS submitted a document entitled *DOJ Settlement Agreement Library Protocol*, dated June 30, 2020. As described above with regard to CI 41.01, the protocol described the requirements for maintaining and updating the Library site at http://dojsettlementagreement.virginia.gov/. The protocol indicates a Subject Matter Expert (SME) or Business Owner is assigned to each provision of the Settlement Agreement and is responsible for reviewing all documents required for each assigned provision to be posted to the Library. Further, it states that all documents must be reviewed and updated as necessary to ensure the Library includes all current documentation of the Commonwealth's compliance with the Settlement Agreement. The protocol also requires an annual audit. However, in interview, the DBHDS Settlement Agreement Coordinator stated the audit process was behind schedule. Based on review of the documentation available the Library site and/or DBHDS website during this 19th Period review (i.e., as of 10/8/21), many of the designated reports for CI 41.05 were not available or were outdated. The following describes the findings for each of the criteria for this CI: a. Results of licensing findings resulting from inspections and investigations: • On the Library Site: Risk Management Review Committee Annual Report, July 1, 2018-June 30, 2019 • On the DBHDS website: *Developmental Disability Licensed Providers with Conditional Licenses 2016-2017*; *Developmental Disability Licensed Providers with Provisional Licenses*, 2017; Provider Inspection/Investigation Reports Search engine. b. Data Quality Plan: • On the Library Site: *Data Quality Roadmap*, Presented to Office Directors - May 21, 2019	17th Not Met 19th Not Met

Compliance Indicator	Facts	Analysis	Conclusion
report and updates to IFSP Plan i. Integrated Residential Services Report j. Integrated Day Services Report k. DBHDS Annual Report l. National Core Indicators Annual Report and Bi-Annual National Report.	41.05 were not available or were outdated.	• On the BHDS website: None found c. Annual Quality Service Review: • On the Library Site: None found • On the DBHDS website: None found d. Annual REACH Report on crisis system: • On the Library Site: o Adult REACH Annual Report Fiscal Year 2019 o Child REACH Annual Report Fiscal Year 2019 • On the DBHDS website: Provider Development webpage lists Reach ReportsFY16-FY18, but the link is not functional e. Semi-Annual Supported Employment Report: • On the Library Site: o DBHDS Semiannual Report on Employment Semi Annual Report (June 2019 Data) 10/3/2019 o Employment First Plan o FY 2018 - FY 2020 Plan Revised August 18, 2018 4th Quarter Update FY 19 • On the DBHDS website: o Provider Development webpage provides link to the DBHDS Semiannual Report on Employment Semi Annual Report (December 2016 Data) o The DOJ Settlement Agreement page provides links to The Virginia Board for People with Disabilities Annual Reports for 2017 and to the 2016 Community Partnerships VA state Rehabilitation council (SRC) annual report f. RST Annual Report, including barriers to integrated services: • On the Library Site: None found • On the DBHDS website: Provider Development webpage provides links to FY20 2nd Quarter and FY20 3rd Quarter RST Reports	

Compliance Indicator	Facts	Analysis	Conclusion
		g. Semi-annual Provider Data Summary Report: provides information on geographic and population based disparities in service availability as well as barriers to services by region • On the Library Site: Provider Data Summary, May 2020 • On the DBHDS website: Provider Development webpage provides link to Provider Data Summary Semi-Annual Report State Fiscal Year 2020-2021 May 1, 2020, to October 31, 2020. h. Integrated Residential Services Report: i. On the Library Site: • DBHDS Independent Housing Outcomes Table December 2019 • Virginia's Plan to Increase Independent Living Options - Action Plan Update Date: January 27, 2020 • HCBS Residential Settings, as of Sep 30, 2019 • Children's ICF/IID • Single Point of Entry and Level of Care Review Cumulative and 2nd Quarterly Report FY20 • Provider Data Summary, May 2020 j. On the DBHDS website: • Provider Development webpage provides link to Provider Data Summary Semi-Annual Report State Fiscal Year 2020-2021 May 1, 2020 to October 31, 2020 • The DOJ Settlement Agreement page provides link to 2016 Community Partnerships VA state Rehabilitation council (SRC) annual report k. Integrated Day Services Report: • On the Library Site: o Community Engagement Plan, 4th Quarter Update FY 19, dated 7/15/2019 o Provider Data Summary, May 2020 • On the DBHDS website: o Provider Development webpage provides link to the DBHDS Semiannual Report on Employment Semi Annual Report (December 2016 Data)	

Compliance Indicator	Facts	Analysis	Conclusion
		○ Provider Development webpage provides link to Provider Data Summary Semi-Annual Report State Fiscal Year 2020-2021 May 1, 2020, to October 31, 2020 l. DBHDS Annual Report: • On the Library Site: Not found • On the DBHDS website: The DOJ Settlement Agreement page provides link to DBHDS Fiscal Year 2016 Annual report (313,J) m. National Core Indicators Annual Report and Bi-Annual National Report: • On the Library Site: Not found • On the DBHDS website: The DOJ Settlement Agreement page provides links to most recent available NCI reports: 1) 2016 Adult Family Survey Report (Family Members Over the Age of 18 Who Use Services) and 2) Comparison of Virginia Data (FY 2014, 2015, and 2016) with National Data (FY 2015). Overall, for this CI and the remainder of the CIs for this provision, DBHDS should address the timeliness with which it makes important information available to stakeholders and general public. It was also notable that, during this study period, the consultant found often difficult to locate documents on the Library Site or the DBHDS website. There is not a functional search engine or a site map for either website, so even if current documents were posted, it was often time-consuming to access them. As described with regard to CI 49.05, based on interviews a sample of 11 providers interviewed, each indicated they had difficulties locating specific information on the DBHDS website. As recommended for that CI, DBHDS should conduct an analysis of its websites and make modifications to simplify the process.	

V.E.1 Analysis of 19th Review Period Findings

Section V.E.1: The Commonwealth shall require all providers (including Training Centers, CSBs, and other community providers) to develop and implement a quality improvement ("QI") program, including root cause analyses, that is sufficient to identify and address significant service issues and is consistent with the requirements of the DBHDS

Compliance Indicator	Facts	Analysis	Conclusion
42.01: DBHDS, through its regulations, requires DBHDS-licensed providers, including CSBs, to have a quality improvement (QI) program that: a. Is sufficient to identify, monitor, and evaluate clinical and service quality and effectiveness on a systematic and ongoing basis; b. Uses standard QI tools, including root cause analysis; c. Includes a QI plan that: i. is reviewed and updated annually, ii. defines measurable goals and objectives; ongoing basis; b. Uses standard QI tools, including root cause analysis; c. Includes a QI plan that: i. is reviewed and updated annually, ii. defines measurable goals and objectives; iii. includes	DBHDS regulations require DBHDS-licensed providers, including CSBs, to have a quality improvement (QI) program. The regulations, at 12VAC35-105-620, address each of the criteria a. through c. For this current review, DBHDS provided a final *Office of Licensing Guidance for a Quality Improvement Program* dated 11/28/2020 to describe how they ensured these regulations were implemented.	At the time of the previous review, the Commonwealth had issued emergency regulations at *12 VAC 35-105-620* to require licensed providers to develop and maintain quality improvement programs. For this review, DBHDS staff reported the Commonwealth had finalized the regulations at *12VAC35-105-620*, entitled "Monitoring and evaluating service quality." The current regulations address each of the requirements of CI 42.01 as follows: *A. The provider shall develop and implement written policies and procedures for a quality improvement program sufficient to identify, monitor, and evaluate clinical and service quality and effectiveness on a systematic and ongoing basis.* *B. The quality improvement program shall utilize standard quality improvement tools, including root cause analysis, and shall include a quality improvement plan.* *C. The quality improvement plan shall:* *1. Be reviewed and updated at least annually;* *2. Define measurable goals and objectives;* *3. Include and report on statewide performance measures, if applicable, as required by DBHDS;* *4. Monitor implementation and effectiveness of approved corrective action plans pursuant to 12VAC35-105-170; and* *5. Include ongoing monitoring and evaluation of progress toward meeting established goals and objectives.* *D. The provider's policies and procedures shall include the criteria the provider will use to* *1. Establish measurable goals and objectives ;* *2. Update the provider's quality improvement plan; and,* *3. Submit revised corrective action plans to the department for approval or continue implementing the corrective action plan and put into place additional measures to prevent the recurrence of the cited violation and address identified systemic deficiencies when reviews determine that a corrective action was fully*	17th Met 19th Met

Compliance Indicator	Facts	Analysis	Conclusion
and reports on statewide performance measures, if applicable, as required by DBHDS; iv. monitors implementation and effectiveness of approved corrective action plans; and v. includes ongoing monitoring and evaluation of progress toward meeting established goals and objectives.		*implemented but did not prevent the recurrence of the cited regulatory violation or correct a systemic deficiency pursuant to12VAC35-105-170.* E. *Input from individuals receiving services and their authorized representatives, if applicable, about services used and satisfaction level of participation in the direction of service planning shall be part of the provider's quality improvement plan. The provider shall implement improvements, when indicated.* The primary revision from the previous emergency regulations was to require providers to develop and implement written policies and procedures to address the remaining regulatory requirements. Regarding the Commonwealth's performance implementing these regulatory requirements, for this 19th Period review, DBHDS's provided a final *Office of Licensing Guidance for a Quality Improvement Program* dated 11/28/2020 to describe how they ensured the final regulations at *12VAC35-105-620* were implemented. However, as described with regard to CI 32.03 and 32.04 above, DBHDS did not provide evidence to show that DBHDS-licensed providers, including CSBs, had completed any needed corrective action to address quality improvement plan deficiencies related to provider staff training. Due to the significant delay by DBHDS in providing requested documents for review, this study could not complete any independent examination of the implementation of the regulatory requirements and cannot validate whether provider QI programs meet the criteria. In future review periods, the Commonwealth's performance monitoring the extent to which providers are implementing this Indicator will be determined at Compliance Indicator 29.02.	
42.02: DBHDS has published written guidance for providers on developing and implementing the requirements of 12 VAC	For this review period, DBHDS had issued a final *Office of Licensing Guidance for a Quality Improvement Program* dated 11/28/2020 as well as a final *Guidance for Serious*	At the time of the 17th Period review, DBHDS provided an updated draft *Office of Licensing Guidance for a Quality Improvement Program* dated 09/28/2020. However, that guidance documents clearly stated a requirement for reviewing serious incidents as part of the quality improvement program. The document only included a reference to serious injuries as an example of how a provider might word a measurable objective.	17th Not Met 19th Met

Compliance Indicator	Facts	Analysis	Conclusion
35-105-620 consistent with the regulation as in effect on October 1, 2019, including reviewing serious incidents as part of the quality improvement program, and will update and revise this guidance as necessary as determined by DBHDS.	*Incident Reporting*, also effective as of 11/28/20. These documents addressed the requirements consistent with regulations.	For this review period, DBHDS had issued a final *Office of Licensing Guidance for a Quality Improvement Program* dated 11/28/2020 as well as a final *Guidance for Serious Incident Reporting*, also effective as of 11/28/2020. The former guidance document did not state a specific requirement for reviewing serious incidents as part of the quality improvement program. However, the *Guidance for Serious Incident Reporting* referenced regulations at 12VAC35-105-160, entitled "Reviews by the department; requests for information; required reporting," including the following at subsection C: " The provider shall collect, maintain, and review at least quarterly all serious incidents, including Level I serious incidents, as part of the quality improvement program in accordance with 12VAC35-105-620 to include an analysis of trends, potential systemic issues or causes, indicated remediation, and documentation of steps taken to mitigate the potential for future incidents." The *Guidance for Serious Incident Reporting* included the following guidance, along with an example of the steps a provider might take to implement the requirements: *"The reason for provider monitoring of Level I, II and III serious incidents is to minimize the risk of any future serious incidents. Provider quality improvement plans, required by 12VAC35-105-620, must address how the provider will identify trends and systemic issues and indicate remediation and the steps taken to mitigate (reduce or alleviate) the potential for future incidents.*" <u>DBHDS should develop a policy, procedure or operational protocol to show how DBHDS staff will determine whether updates and/or revisions to this guidance are necessary.</u> For example, the results of licensing surveys might reveal areas of widespread non-compliance, or provider feedback with regard to the adequacy of the guidance, could indicate a need for expanding or modifying the guidance document. In interview, staff provided some description of how they might use data from licensing surveys for quality improvement in this area. However, DBHDS should develop the requisite policy, procedure and/or operational protocol to describe how DBHDS staff will determine whether updates and/or revisions to this guidance are necessary	

Compliance Indicator	Facts	Analysis	Conclusion
42.03: On an annual basis at least 86% of DBHDS licensed providers of DD services have been assessed for their compliance with 12 VAC 35-105- 620 during their annual inspections.	DBHDS staff submitted a PMI template entitled "Licensed providers meet the regulatory requirements for quality improvement programs," but the three measures included in that documents did not describe a specific data collection methodology for this measure that would produce valid and reliable data. In addition, based on the findings for CI 36.01 and CI 38.01, the Office of DQV had not yet determined that the applicable data source system produced valid and reliable data, so the data relied upon cannot be used to support compliance findings.	DBHDS staff submitted a PMI template entitled "Licensed providers meet the regulatory requirements for quality improvement programs." It included three measures, including the following: • Measure #1 - (Not stated) o Numerator: The number of licensed providers, by service, that were determined to be compliant with each of the quality improvement regulations (620) during an unannounced annual inspection; reported separately. o Denominator: The number of licensed providers, by service that had a review of their compliance with quality improvement regulations during an unannounced annual inspection. • Measure #2 – The percentage of providers, by service, that were determined to be compliant with at least 86% of the applicable quality improvement regulations during their unannounced annual inspection. o Numerator: The number of licensed provider, by service, that were determined to be compliant with at least 86% of the quality improvement regulations that were able to be reviewed during their annual unannounced inspection. o Denominator: The number of licensed providers, by service that had a review of their compliance with quality improvement regulations during an annual inspection. • Measure #3 – The percentage of providers, by service, that were determined to be compliant with 100% of the applicable quality improvement regulations during their unannounced annual inspection. o Numerator: The number of licensed provider, by service, that were determined to be compliant with 100% of the quality improvement regulations that were able to be reviewed during their annual unannounced inspection. o Denominator: The number of licensed providers, by service, that had a review of their compliance with quality improvement regulations during an annual inspection. None of these measures explicitly address the requirements of CI 42.03 For this CI, the Numerator should report the number of providers assessed or, to be consistent with the existing methodology, the number of providers, by service,	17th Met 19th Not Met

Compliance Indicator	Facts	Analysis	Conclusion
		assessed. According to the data collection methodology described in the PMI, *DW-0097* includes this data point. Based on the wording of this CI, the Denominator should be the number of licensed providers of DD services. Of note, the document request for this study asked for a list of providers by region, but the DBHDS Settlement Agreement Coordinator indicated that this list changed on an ongoing basis and could not be produced. This was troubling, in any event; however, in order to report the metric required by this CI, it will be necessary for DBHDS to develop a written methodology by which it can report the total number of licensed providers against which it will compare the number of fully compliant providers. So, the methodology for this measure should include how DBHDS will take this into account in calculating the denominator. The measure for this CI is also necessary to inform the understanding of how well, or whether, the three measures in the relevant PMI address the requirements for CI 42.04 below or the purported description of the purpose of the PMI (i.e., licensed providers meet the regulatory requirements for quality improvement programs.) Overall, the PMI lacked clarity about how DBHDS has chosen to address the denominator for all three of these measures. The denominators appeared to potentially exclude some number of providers that did not have an assessment of review of their compliance with quality improvement regulations during their annual inspections. On its face, this would appear to invalidate the measures for the purpose of demonstrating compliance. The Business Definitions & Processes section of the PMI define the following: • Non-applicable is only used when a specific regulation does not apply to a provider • Non-determined is used when a licensing specialist is unable to make a compliance determination because the provider did not have any events during the review period that are covered by the regulation. For example, a provider would have a determination of "Non-determined" for 620.C.4 (monitor implementation and effectiveness of corrective action plans) if they did not have any corrective action plans during the review period.	

Compliance Indicator	Facts	Analysis	Conclusion
		These business rules appeared to explain some potential discrepancies. In the measures, this could be resolved by referencing the "applicable" regulations (e.g., The number of licensed providers, by service, that had a review of their compliance with "applicable" quality improvement regulations during an annual inspection.) However, these documented exceptions do not appear to address some of the data findings provided for review. • For the period 1/1/21through 3/31/21, DBHDS provided a report, entitled *DW-0097* that documented the percentage of providers reviewed who were assessed for compliance with each of 13 components of the licensing regulations. The 13 components were 620.A, 620.B, 620.C, 620.C.1, 620.C.2, 620.C.3, 620.C.4, 620.C.5, 620.D, 620.D.1, 620.D.2, 620.D.3, and 620.E. The percentages ranged from 87.09% of reviewed providers that were assessed for compliance with 620.D to 92.49% of reviewed providers for 620.A. • For the period 4/1/21 through 6/30/21, DBHDS provided *DW-0097* for ten components of the licensing regulations. The ten components included 620.C.1, 620.C.2, 620.C.3, 620.C.4, 620.C.5, 620.D, 620.D.1, 620.D.2, 620.D.3, and 620.E. The percentages ranged from 80.98% of reviewed providers that were assessed for compliance with 620.D to 96.54% for 620.C.3. The data reported sometimes did not make clear why some providers inspected were not reviewed for the specific regulations. For example, for the regulation 620.C.1,which requires that the provider quality management plan be reviewed and updated at least annually, the report showed that a total of 347 providers were inspected and 327 were reviewed for this regulation. The report showed that none were considered non-applicable, so it was not clear why 20 providers that received an inspection were not reviewed for this indicator. Based on the business rules defined in the PMI, if none of the providers were non-applicable	

Compliance Indicator	Facts	Analysis	Conclusion
		for this regulation, it would appear to follow that all 347 would have been reviewed rather than 327. Other columns showed 243 providers were found to be compliant and 16 had a "non-determined" finding. In other words, 259 had a reported finding. Although the report did not show the number of noncompliant providers, one could assume that number would have been 68 [i.e., the number reviewed (327) less the number with a compliance or non-determined finding (259)]. A column entitled "Percentage Compliance Over Reviewed" indicate the percentage for regulation 620.C.1 was 78.14%. It was not clear how this was calculated. For example, if the number compliant (i.e., the numerator) was 243 and the number reviewed was 327 (i.e., the denominator), the resulting percentage would appear to be 74.3%. If, instead, the numerator was 227 [i.e., the number compliant (243) minus the number non-determined) and the denominator remained 327 (i.e., the number reviewed), the resulting percentage would appear to be 69.4%. In either case, the percentage was lower than the report indicated. Of note, this still did not take into account the 20 inspected providers that were not reviewed for this regulation. While it is possible that the Office of Licensing has some other protocols staff took into account, they were not clearly represented in the PMI methodology. Of note, the Office of DQV assisted the Measure Steward with developing and drafting the initial measure on 9/18/20 and did not identify any potential threats to PMI validity or reliability at that time. DBHDS should complete an annual review of the measure to be sure the business rules and definitions are comprehensively stated, and that data are being collected in a consistent and accurate manner. In any event, based on the findings for CI 36.01 and CI 38.01, the Office of DQV had not yet determined that the applicable data source system produced valid and reliable data, so the data relied upon cannot be used to support compliance findings.	
42.04: On an annual basis, at least 86% of DBHDS-		DBHDS submitted a PMI template for the measure "86% of licensed DD providers, by service were determined to be compliant with the quality improvement regulations reviewed during an unannounced annual inspection."	17th Not Met 19th Not Met

Compliance Indicator	Facts	Analysis	Conclusion
licensed providers of DD services are compliant with 12 VAC 35-105-620. Providers that are not compliant have implemented a Corrective Action Plan to address the violation.		The Numerator for this CI was the "number of licensed DD providers, by service, that were determined to be compliant with 100% of the quality improvement regulations assessed during an annual unannounced inspection.). The Denominator was the "number of licensed DD providers, by service, that were assessed for quality improvement regulations during an annual unannounced inspection. As further described with regard to CI 42.03, it did not appear that the business rules and definitions would necessarily provide a valid denominator for this CI. In other words, all DD-licensed providers should have had a review of their compliance with *12 VAC 35-105-620*, but the denominator again appeared to allow for providers to receive an inspection, but not a review of the quality improvement regulations. On its face, this would impact the validity of the measure for the purpose of showing compliance with this CI . Of note, on 7/7/21, the Data Steward consulted with Office of DQV staff to assist with updating the document based on improvements to the methodological and data source report. At the time of the July 2021 review, they did not identify any potential threats to PMI validity or reliability. Office of DQV staff should complete an additional review to ensure this is a valid measure for reporting on this CI. DBHDS provided the following data for review: • For the period 1/1/21 through 3/31/21, DBHDS provided a report, entitled *DW-0097* that documented the percentage of providers that were assessed during that period for compliance with 13 components of the licensing regulations, as described with regard to that same timeframe in CI 42.03. The compliance percentages ranged from 75.99% for 620.D.2 to 93.21% for 620.C. • For the period 4/1/21through 6/30/21, DBHDS provided DW-0097 for ten components of the licensing regulations, as described	

Compliance Indicator	Facts	Analysis	Conclusion
		with regard to that same timeframe in CI 42.03. The compliance percentages ranged from 63.37% for 620.D.3 to 86.38% for 620.D. For quality improvement purposes, it will be useful to report compliance levels for each of the components of the licensing regulations, as this will allow DBHDS to focus systemic guidance and corrective actions. However, to assess compliance with this CI, it will be necessary for DBHDS to report data that show the percentage of all DD-licensed providers that achieved compliance with 100%of the applicable components annually.	
42.05: DBHDS has policies or Departmental Instructions that require Training Centers to have quality improvement programs that: a. Are reviewed and updated annually; b. Has processes to monitor and evaluate quality and effectiveness on a systematic and ongoing basis; c. Use standard quality improvement tools, including root cause analysis; d. Establish facility-wide quality improvement initiatives; and e. Monitor implementation and effectiveness of quality improvement initiatives.	DBHDS provided an updated *Departmental Instruction 316 (QM) 20, Quality Improvement, Quality Assurance, and Risk Management for Individuals with Developmental Disabilities* (DI 316), which addressed all of addressed all of the requirements for CI 42.05. DBHDS did not provide any current documentation to show the Training Center had procedures, protocols and/or processes to monitor and evaluate quality and effectiveness on a systematic and ongoing basis; to show that the Training Center used standard quality improvement tools, including root cause analysis; to show that the Training Center established facility-	At the time of the 17th Period review, DBHDS provided *Departmental Instruction 316 (QM) 20, Quality Improvement, Quality Assurance, and Risk Management for Individuals with Developmental Disabilities* (DI 316). It only broadly stated the requirement and expectations for the establishment of a quality improvement program. For example, DI 316 did not specifically require that the QI program be reviewed and updated annually, that Training Center used standard quality improvement tools or the establishment and monitoring of facility-wide quality improvement initiatives. In addition, DBHDS provided DI 301, dated 7/01/99, and DI 401 updated 9/4/20, which addressed Training Center requirements for implementation of quality improvement and risk management programs, respectively. Taken collectively, they addressed most of the requirements, but did not clearly state a requirement for the use of root cause analysis in the quality improvement program. For this review, DBHDS provided an updated DI 316, effective 04/7/21. The document addressed all of the requirements for CI 42.05. With regard to root cause analysis, Section 316-7 addressed the previously noted deficiency, as follows: *"All training centers are required to develop and implement a quality improvement program that includes root cause analysis and the use of other quality tools as deemed appropriate, which identifies and addresses significant issues and is in compliance with DI301 and DI401.* However, DBHDS did not provide any documentation for this review period to show the Training Center had procedures, protocols and/or processes to	17th Not Met 19th Not Met

Compliance Indicator	Facts	Analysis	Conclusion
	wide quality improvement initiatives; or to show that the Training Center monitored implementation and effectiveness of quality improvement initiatives	monitor and evaluate quality and effectiveness on a systematic and ongoing basis; to show that the Training Center used standard quality improvement tools, including root cause analysis; to show that the Training Center established facility-wide quality improvement initiatives; or to show that the Training Center monitored implementation and effectiveness of quality improvement initiatives.	

V.E.2 Analysis of 19th Review Period Findings

Section V.E.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.

Compliance Indicator	Facts	Analysis	Conclusion
43.01: DBHDS has developed measures that DBHDS-licensed DD providers, including CSBs, are required to report to DBHDS on a regular basis, and DBHDS has informed such providers of these requirements. The sources of data for reporting shall be such providers' risk management/critical incident reporting and their QI program. Provider reporting	DBHDS developed measures based on data that DBHDS-licensed DD providers, including CSBs, are required to report to DBHDS on a regular basis. DBHDS provided a list of provider reporting measures and designated each as assessing either a positive of negative aspect of health and	At the time of the 17th Period review, DBHDS had not fully developed processes for provider measure reporting. For this review, DBHDS had developed measures based on data that DBHDS-licensed DD providers, including CSBs, are required to report to DBHDS on a regular basis. DBHDS provided a list six provider reporting measures and identified each as assessing either a positive of negative aspect of health and safety and of community integration. The list included both types (i.e., positive and negative aspects) of measures and were selected from relevant domains listed in Section V.D.3. These are illustrated in the table below, which also identifies the data source system for each Provider Reporting Measure | Data Source	17th Not Met 19th Not Met

Compliance Indicator	Facts	Analysis		Conclusion
measures must: a. Assess both positive and negative aspects of health and safety and of community integration; b. Be selected from the relevant domains listed in Section V.D.3 above; and c. Include measures representing risks that are prevalent in individuals with developmental disabilities (e.g., aspiration, bowel obstruction, sepsis) that are reviewed at least quarterly by the designated sub-committee as defined by the Quality Management Plan.	safety and of community integration. The list included both types (i.e., positive and negative aspects) of measures, were selected from relevant domains listed in Section V.D.3. The data for reporting these measures is aggregated by DBHDS from the critical incident reporting system (CHRIS-SIR) and from the ISP data entry in WaMS. For the measures for which data are collected through WaMs, DBHDS informed providers of these requirements through regulations at 12VAC35-105-675. DBHDS also reported that the performance contract with CSBs required them to enter information gathered through the ISP process into the electronic ISP in WaMS. However, they did not provide a copy	Positive Aspects of Health and Safety		
		Eighty-seven percent (87%) of individuals with an active waiver status in WaMS will have a documented annual physical exam date (approximate or actual).	ISPs in WaMS	
		Seventy-five percent (75%) of individuals with an active waiver status and a documented annual physical exam date in their ISP in WaMS will have an actual annual1 physical exam date recorded.	ISPs in WaMS	
		Negative Aspects of Health and Safety		
		Rate of incidents per 1,000 waiver recipients for each of the following: • aspiration pneumonia • bowel obstruction • sepsis • decubitus ulcer • fall or trip • dehydration • seizures • choking • urinary tract infection • self-injury • sexual assault • suicide attempt	CHRIS-SIR (Individual incident reports)	
		Positive Aspects of Community Integration		
		86% of individuals with an active waiver are involved in their community.	ISPs in WaMS	
		75% of individuals with an active waiver are involved in their community through the most integrated support.	ISPs in WaMS	
		Negative Aspects of Community Integration		
		Percentage of individuals with an active waiver who have an identified barrier due to either: • behavioral	ISPs in WaMS	

Compliance Indicator	Facts	Analysis	Conclusion
	of the performance contract for review to confirm this assertion. For the measures for which data are collected through CHRIS-SIR, DBHDS informed providers of these requirements through regulations at 12VAC35-105-160. Based on the facts described for CI 38.01, due to data quality concerns with regard to the data source systems for these measures, the data reviewed cannot be confirmed to be valid and reliable and cannot be used for compliance reporting. This CI also requires that the sources of data for reporting shall be such providers' risk management/critical incident reporting *and* (emphasis added) their QI program and regulations at 12VAC35-105-160 and	• medical • other As the table also illustrates, DBHDS indicated that the data for reporting these measures is aggregated from the critical incident reporting system (CHRIS-SIR) and from the ISP data entry in WaMS. For the measures for which data are collected through WaMs, DBHDS informed providers of these requirements through regulations at 12VAC35-105-675. DBHDS also reported that the performance contract with CSBs required them to enter information gathered through the ISP process into the electronic ISP in WaMS. However, they did not provide a copy of the performance contract for review to confirm this assertion. For the measures for which data are collected through CHRIS-SIR, DBHDS informed providers of these requirements through regulations at *12VAC35-105-160*. Based on the facts described for CI 38.01, due to data quality concerns with regard to the data source systems for these measures (i.e., WaMS and CHRIS-SIR), the data reviewed cannot be confirmed to be valid and reliable and cannot be used for compliance reporting. DBHDS also did not submit specific PMI templates for one of the measures (i.e., percentage of individuals with an active waiver who have an identified barrier due to either behavioral, medical or other) to describe the data collection methodology, so there was no evidence that the Office of DQV had completed a review of data validity and reliability. As further described with regard to CI 43.03 below, the Office of DQV review of the data collection methodology identified other threats to data validity and reliability for two of the remaining measures, and had not completed a review of a third after the data collection methodology was updated. In addition, this CI requires that the sources of data for reporting shall be DD-licensed providers' risk management/critical incident reporting *and* (emphasis added) their QI program. As reported previously, DBHDS does not obtain data with regard to these measures from providers' QI programs. In addition, DBHDS does not report the data out in a manner that allow providers to use them for their own quality improvement needs (i.e., the data reporting is not broken down by provider.)	

Compliance Indicator	Facts	Analysis	Conclusion
	DBHDS guidance (i.e., *Guidance for Serious Incident Reporting*) require providers and CSBs to collect, maintain, and review at least quarterly all serious incidents, as part of the quality improvement program, including an analysis of trends, potential systemic issues or causes, indicated remediation, and documentation of steps taken to mitigate the potential for future incidents. As reported previously, however, DBHDS does not obtain data with regard to these measures from providers' QI programs.	As discussed above with regard to CI 42.02, DBHDS issued guidance (i.e., *Guidance for Serious Incident Reporting*) that referenced regulations at 12VAC35-105-160, including the following at subsection C: " The provider shall collect, maintain, and review at least quarterly all serious incidents, including Level I serious incidents, as part of the quality improvement program in accordance with 12VAC35-105-620 to include an analysis of trends, potential systemic issues or causes, indicated remediation, and documentation of steps taken to mitigate the potential for future incidents." As such, it appeared that providers should be able to report their own performance measurement as required by CI 43.01. For purposes of quality improvement, as well as transparency, it would also appear to be in the best interest of DBHDS, as well as the providers, CSBs and stakeholders, to report out the specific provider-level data.	
43.02: DBHDS requires regular reporting, at least annually, of each provider reporting measure from DBHDS-licensed DD providers. Measures referenced in indicators #1.c are reported quarterly. 86% of such providers report the measure as required.	As described above in V.D.3, DBHDS had a process in place for regular reporting of PMI data. However, as described with regard to CI 43.01 above, DBHDS staff did not provide PMI templates for one of the measures,	As described above in V.D.3, DBHDS had a process in place for regular reporting of PMI data. However, as described with regard to CI 43.01 above, DBHDS staff did not provide PMI templates for one of the measures, and no data were reported for it. However, based on the findings for CI 36.01 and CI 38.01, the Office of DQV had not yet determined that the applicable data source systems produced valid and reliable data, so the data cannot be used to support compliance findings. In addition, as described with regard to CI 43.01 above, DBHDS staff did not provide PMI templates for one of the measures.	17th Not Met 19th Not Met

Compliance Indicator	Facts	Analysis	Conclusion
	and no data were reported for it. In addition, based on the findings for CI 36.01 and CI 38.01, the Office of DQV had not yet determined that the applicable data source systems produced valid and reliable data, so the data cannot be used to support compliance findings.		
43.03: The DBHDS Office of Data Quality and Visualization assists with analysis of each provider reporting measure to ensure that the data sources are valid, identify what the potential threats to validity are, and ensure that the provider reporting measures are well-defined and measure what they purport to measure. The QIC or designated subgroup will review and assess each provider reporting measure annually and update accordingly.	DBHDS did not provide documentation to show that the Office of DQV completed all needed assistance with analysis of all provider reporting measures to ensure that the data sources are valid, identify what the potential threats to validity are, and ensure that the provider reporting measures are well-defined and measure what they purport to measure. Although they provided documentation of review and assistance with	Beginning with measures active for SFY20 or after, the Office of DQV assists with the analysis of each PMI to ensure that the data sources are valid, identify the potential threats to reliability and ensure that the provider reporting measures are well-defined and measure what they purport to measure. As described above with regard to CI 43.01, based on review of the measure templates for the PMIs, DBHDS did not submit PMI templates for one of the provider measures. For the provider measures that for which DBHDS did provide PMI templates, the Office of DQV had not completed an annual review for the following: • Seventy-five (75%) of individuals with an active waiver are involved in their community through the most integrated support: The Office of DQV reviewed this measure in June 2020 and did not identify any potential threats to PMI validity or reliability at that time. There was not an annual review documented. In addition, as described with regard to CI 36.01, the PMI template did not evidence a review by the Office of DQV following the most recent update on 2/25/21. • Seventy-five percent (75%) of individuals with an active waiver status and a documented annual physical exam date in their ISP in WaMS will have an actual annual physical exam date recorded.: The Office of DQV	17th Not Met 19th Not Met

Compliance Indicator	Facts	Analysis	Conclusion
	analysis for four of six measures, for three of those four, the assistance was not current, thorough, or otherwise complete. Based on the findings for CI 36.01 and CI 38.01, the Office of DQV had not yet determined that the applicable data source systems produced valid and reliable data, so the data cannot be used to support compliance findings.	last reviewed this measure in June 2020 and noted potential threats to PMI validity and reliability: • Eighty-seven percent (87%) of individuals with an active waiver status in WaMS will have a documented annual physical exam date (approximate or actual): The Office of DQV last reviewed this measure in June 2020 and noted potential threats to PMI validity and reliability. In addition, based on the findings for CI 36.01 and CI 38.01, the Office of DQV had not yet determined that the applicable data source systems produced valid and reliable data, so the data cannot be used to support compliance findings.	
43.04: Provider reporting measures are monitored and reviewed by the DBHDS Quality Improvement Committee ("QIC") at least semi-annually, with input from Regional Quality Councils, described in Section V.D.5. Based on the semi-annual review, the QIC identifies systemic deficiencies or potential gaps, issues recommendations, monitors the measures, and makes revisions to quality improvement initiatives as needed, in accordance with DBHDS's Quality	For this review, the QIC monitored and reviewed PMIs designated as provider reporting measures, for which DBHDS had created PMI templates, on a quarterly basis. For one of the provider reporting measures, DBHDS did not submit documentation to show it developed a PMI template to establish a data collection methodology.	At the time of the 17th Period review, the QIC monitored and reviewed PMIs on a quarterly basis and it appeared that the QIC had promulgated procedures that would likely be effective for using available data to identify systemic deficiencies or potential gaps, to issue recommendations, to monitor the measures, and to make revisions to quality improvement initiatives as needed. However, at that time, DBHDS did not yet have provider reporting measures for all required domains (i.e., for risks that are prevalent for the population of individuals with developmental disabilities.) For this review, the meeting minutes reflected that the QIC monitored and reviewed PMIs designated as provider reporting measures, for which DBHDS had created PMI templates, on a quarterly basis. In some instances (e.g., for sepsis and UTIs), DBHDS used data with regard to these risks to identify systemic issues and develop QIIs. However, as described above with regard to CI 43.01 and CI 43.03, for one of the provider reporting measures, DBHDS did not submit documentation to show it developed a PMI template to establish a data collection methodology.	17th Not Met 19th Not Met

Compliance Indicator	Facts	Analysis	Conclusion
Management System as described in the indicators for V.B.	Based on the facts described for CI 36.06, CI 38.06 and CI 43.03, the data reviewed cannot be confirmed to be valid and reliable and cannot be used for compliance reporting.	As described with regard to Section V.D.5 above, the Regional Quality Councils' meeting minutes sometimes showed they reviewed data related to PMIs designated as provider reporting measures on a quarterly basis. For example, minutes for all five regions generally demonstrated some level of review of the rates of risk conditions. However, this was not consistent for all provider reporting measures or across meeting minutes for all four quarters. As described with regard to CI 39.04 above, the documentation for the third and fourth quarters (i.e., for the period of 1/1/21through 6/30/21) showed significant improvement over the first two quarters. These minutes were made available to the QIC. Based on the QIC review of the provider reporting measures, the QIC continued to make efforts to identify systemic deficiencies or potential gaps, issues recommendations, monitors the measures, and makes revisions to quality improvement initiatives as needed, in accordance with DBHDS's Quality Management System. For example, as described with regard to CI 32.07, based on the RMRC review of data for 327 UTI reports, from the period 10/1/19 through 9/30/20, in March 2021, OIH published an updated Health and Safety Alert on Urinary Tract Infections, and focused on National Kidney Month in the OIH Health Trends Newsletter. In addition, they made plans to review and update existing provider training and educational resources (e.g., atypical signs and symptoms of UTI; Skill building related to personal care/hygiene; discussing body parts; health literacy; how other diagnoses, diseases, and medications interplay with a diagnosis of a UTI, etc.) However, based on the facts described for CI 36.06, CI 38.06 and CI 43.03, the data reviewed cannot be confirmed to be valid and reliable and cannot be used for compliance reporting.	

V.E.3 Analysis of 19h Review Period Findings

Section V.E.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.

Compliance Indicator	Facts	Analysis	Conclusion
44.01: In addition to monitoring provider compliance with the DBHDS Licensing Regulations governing quality improvement programs (see indicators for V.E.1), the Commonwealth assesses and makes a determination of the adequacy of providers' quality improvement programs through the findings from Quality Service Reviews, which will assess the adequacy of providers' quality improvement programs to include: a. Development and monitoring of goals and objectives, including review of performance data. b. Effectiveness in either meeting goals and objectives or development of improvement plans when goals are not met. c. Use of root cause analysis and other QI tools and	For CI 44.01, DBHDS did not provide any documentation to evidence compliance. Compliance with these indicators is predicated on the availability of reliable and valid data from the QSRs. DBHDS did not provide a response to the Independent Reviewer's request for evidence to show that the Office of DQV had assessed the QSR data collection methodologies to determine the reliability and validity of the data those methodologies produced. Therefore, this study could also not confirm that the Commonwealth complied with CI 44.01.	For CI 44.01, DBHDS did not specify any documentation to show how they used QSR data to meet the requirements of that provision. In addition, compliance with these indicators is predicated on the availability of reliable and valid data from the QSRs. As noted above, DBHDS did not provide a response to the Independent Reviewer's request for evidence to show that the Office of DQV had assessed the QSR data collection methodologies to determine the reliability and validity of the data those methodologies produced. Therefore, this study could also not confirm that the Commonwealth complied with CI 44.01.	17th Not Met 19th Not Met

Compliance Indicator	Facts	Analysis	Conclusion
implementation of improvement plans.			
44.02: Using information collected from licensing reviews and Quality Service Reviews, the Commonwealth identifies providers that have been unable to demonstrate adequate quality improvement programs and offers technical assistance as necessary. Technical assistance may include informing the provider of the specific areas in which their quality improvement program is not adequate and offering resources (e.g., links to on-line training material) and other assistance to assist the provider in improving its performance.	As described with regard to CI 44.01, DBHDS did not provide any documentation to evidence compliance with this CI related to data from QSRs. Compliance with these indicators is predicated on the availability of reliable and valid data from the QSRs. DBHDS did not provide a response to the Independent Reviewer's request for evidence to show that the Office of DQV had assessed the QSR data collection methodologies to determine the reliability and validity of the data those methodologies produced. Therefore, this study could also not confirm that the Commonwealth complied with CI 44.02.	As described with regard to CI 44.01, DBHDS did not provide any documentation to evidence compliance with this CI related to data from QSRs. In addition, compliance with these indicators is predicated on the availability of reliable and valid data from the QSRs. As noted above, DBHDS did not provide a response to the Independent Reviewer's request for evidence to show that the Office of DQV had assessed the QSR data collection methodologies to determine the reliability and validity of the data those methodologies produced. Therefore, this study could also not confirm that the Commonwealth complied with CI 44.02.	17th Not Met 19th Not Met

IX.C. Analysis of 19th Review Period Findings

Section IX.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.

Compliance Indicator	Facts	Analysis	Conclusion
54.01: The Commonwealth maintains a written index that identifies the records sufficient to document that the requirements of the Settlement Agreement are being implemented and the entities responsible for monitoring and ensuring that the records are made available ("Record Index").	DBHDS provided two documents that described the protocols for maintenance of the Library Record Index. These included the *Settlement Agreement Library Record Index* and the *DOJ Settlement Agreement Library Protocol*, both of which were effective on June 30, 2020. These documents stated the purpose of the Library Record Index was to identify the records sufficient to document that the requirements of the Settlement Agreement are implemented, as well as the entities responsible for monitoring. However, DBHDS did not provide an updated version for the 19th Period, nor was a Library Record	DBHDS provided two documents for review that described the protocols for maintenance of the Library Record Index. These included the *Settlement Agreement Library Record Index* and the *DOJ Settlement Agreement Library Protocol*, both of which were effective on June 30, 2020. Based on the *Settlement Agreement Library Record Index*, the purpose of the Library Record Index is to identify the records sufficient to document that the requirements of the Settlement Agreement are implemented, as well as the entities responsible for monitoring. Consistent with the requirements of CI 54.01, the *Settlement Agreement Library Record Index* and the *DOJ Settlement Agreement Library Protocol* indicated the Library Record Index will catalogue all documents posted to the Library (http://dojsettlementagreement.virginia.gov/) and will specify the business owner or Subject Matter Expert (SME) responsible for the origination and update of the record. The *Settlement Agreement Library Record Index* also stated that the business owner of the Library overall is the DBHDS Settlement Agreement Coordinator. The *Settlement Agreement Library Record Index* also indicated that the Library Record Index is in the form of a spreadsheet for ease of viewing and tracking, but is a stand-alone document that does not link to the Library itself. Instead, it stated that the Library Record Index is posted in the Library site under provision IX.C. At the time of the 17th Review Period, DBHDS provided a Library Record Index for review, but did not provide an updated version for the 19th Period, nor was a Library Record Index found at the on-line Library site.	17th Not Met 19th Not Met

Compliance Indicator	Facts	Analysis	Conclusion
	Index found at the on-line Library site, as indicated in the protocol documents. In addition, many of the required reports and documents were not available on the Library site or were outdated.	Further, pursuant to the findings for CI 41.01 - 41.03 and 41.05, based on review of the documentation available the Library site during this 19th Period review (i.e., as of 10/8/21), many of the required records were not available or were outdated. As a result of these findings, this review cannot confirm that DBHDS has continued to maintain a written index that identifies the records sufficient to document that the requirements of the Settlement Agreement are being implemented.	
54.02 The Record Index specifies the following components for each record: • Identification and documentation of record locations • Timeframe for collecting and updating records as specified in the Settlement Agreement or as determined by DBHDS Identification of a custodian of the records who is responsible for oversight of the collection, storage, and updates • A process to monitor/audit record completion.	The Library Record Index was not available on the on-line Library website, and DBHDS did not otherwise provide a current document for review.	The *Settlement Agreement Library Record Index* and the *DOJ Settlement Agreement Library Protocol* both indicated that the Library Record Index will specify each of the components required by CI 54.02. However, as described above, the Library Record Index document was not available on the on-line Library website, and DBHDS did not otherwise provide a current document for review, so this study could not verify that there was a current Index that was compliant with these requirements. Therefore, this study could not verify that there was a current Index that was compliant with these requirements.	17th Not Met 19th Not Met
54.03 The Record Index and all associated documents are timely available to the Independent Reviewer upon request.	No Library Record Index document was available on the on-line Library website, and DBHDS did not otherwise provide a current document for review.	As described above with regard to CI 54.01 and CI 54.02, the Library Record Index document was not available on the on-line Library website, and DBHDS did not otherwise provide a current document for review. In addition, as described above, with regard to numerous provisions and CIs, many documents were not provided timely, or provided at all, to the Independent Reviewer upon request, or posted timely to the Library site. In interview, DBHDS staff acknowledged that they could sometimes not provide	17th Not Met 19th Not Met

Compliance Indicator	Facts	Analysis	Conclusion
	Overall, for this Review Period, DBHDS did not provide many documents on a timely basis to the Independent Reviewer upon request.	current records because they were not yet updated and available. DBHDS staff also acknowledged they had not yet completed the annual Library audit process as needed.	
54.04: Records will be maintained in accordance with applicable Library of Virginia Records Retention and Disposition Schedules or longer, as necessary to demonstrate compliance with the Settlement Agreement.	DBHDS had protocols in place that indicated it intended to adhere to the "applicable" Library of Virginia Records Retention and Disposition Schedules, but the protocols did not identify the applicable schedules. In addition, the DBHDS protocols provided for review did not describe the criteria by which DBHDS would make determinations with regard to the applicability of the schedules or whether a longer period would be required as needed to demonstrate compliance with the Settlement Agreement.	Both the *Settlement Agreement Library Record Index* and the *DOJ Settlement Agreement Library Protocol* stated that DBHDS would maintain records in accordance with applicable Library of Virginia Records Retention and Disposition Schedules, but provided no additional detail with regard to those expectations. To verify that the Commonwealth has maintained records in accordance with applicable Library of Virginia Records Retention and Disposition Schedules, the Commonwealth must determine and document, the applicable schedule. The *DOJ Settlement Agreement Library Protocol* also described an archiving procedure, as follows: "All documents posted in the Settlement Agreement Library at the time of initial launch will remain in the main body of the Library for six months. Following the initial six month period, all documents replaced by a new or revised document will be moved to the archive. For example, a new annual report will replace the previous annual report and the previous report will be moved to the archive. All records will remain in the archive and accessible to users in accordance with the applicable Library of Virginia Records Retention and Disposition Schedules." The on-line Library website provided a link to the Library of Virginia Records Retention Schedule. However, it was not clear from a reading of the schedules which, if any, would be considered applicable (i.e., as necessary to demonstrate compliance with the Settlement Agreement) or whether a longer period would be required. The protocol documents did not describe who would make such determinations or the criteria they would rely on for making them.	17th Not Met 19th Not Met

Recommendations

1. Because the continuing deficiencies with regard to the lack of valid and reliable data permeate the findings for many of the CIs reviewed for this study as well as the Independent Reviewer's other 19th Review Period studies, DBHDS should place a primary emphasis on remedial and improvement efforts for the data source systems and PMI data collection methodologies.
2. DBHDS should ensure it has in place a minimum set of finalized policies, procedures, instructions, protocols and/or tools needed to describe how DBHDS uses data and information from risk management activities, including mortality reviews to identify topics for future content; make determinations as to when existing content needs to be revised; and identify providers that are in need of additional technical assistance or other corrective action.
3. DBHDS should update the *DOJ Settlement Agreement - Process Document* to specify action DBHDS would take for CSB non-compliance with annual review of performance measures.
4. DBHDS should work with DMAS to produce the QRT EOY report on a timelier basis so that it can be effectively used for quality improvement purposes.
5 DBHDS should promulgate a PMI data collection methodology for the following measure: The Commonwealth ensures that at least 86% of individuals who are assigned a waiver slot are enrolled in a service within 5 months, per regulations.
6. DBHDS should consider re-visiting the May 2020 draft protocol related to the requirements to collect and analyze statistically valid sample data regarding the management of needs of individuals with identified complex behavioral, health and adaptive support needs.
7. With regard to their QII goals and objectives, the RQCs should fully document the criteria for measurability, to the extent feasible.
8. DBHDS staff should adhere to the expectations described in the *DOJ Settlement Agreement Library Protocol*, dated June 30, 2020, for maintaining, updating and updating the DBHDS Library site with all needed documentation. This should also help to ensure that, going forward, DBHDS is able to provide documentation the Independent Reviewer requests in order to evaluate compliance with the CIs.
9. DBHDS should develop a policy, procedure or operational protocol to show how DBHDS staff will determine whether updates and/or revisions to written guidance for providers on developing and implementing the requirements of 12 VAC 35-105-620 are necessary.
10. DBHDS should implement policies and procedures with regard to the requirement that providers report "provider reporting measure" data from their QI program.

Attachment A: Interviews

1. Heather Norton, Assistant Commissioner, Department of Behavioral Health and Developmental Services
2. Alexis Aplasca, Chief Clinical Officer
3. Dev Nair, Assistant Commissioner, Division of Quality Assurance and Government Relations
4. Jenni Schodt, Settlement Agreement Coordinator
5. Jae Benz, Director of Licensing
6. Debra Vought, Office of Licensing
7. Katherine Means, Senior Director of Clinical Quality Management
8. Britt Welch, Director, Office of Community Quality Improvement
9. Jodi Kuhn, Director, Office of Data Quality and Visualization
10. Rebecca Laubach, Quality Improvement Coordinator
11. Ariel Unser, Data Reporting Specialist, Office of Data Quality and Visualization
12. Deanna Parker, Quality Review Team Manager

Attachment B: Documents Reviewed

1. DI 316 QualityManagement.REVISED.2021.04.07
2. SFY 2020 DD Quality Management Plan Link to DOJ Library.docx
3. Welcome to Root Cause Analysis in Developmental Disabilities
4. Welcome to Risk Screening in Developmental Disabilities
5. Training and Resources
6. CDDER Risk Management Courses_Flyer_VA_Final
7. 520A 1-1-2021 to 9-7-2021 DW-0085-Key Licensing Regulatory Compliance Report (14).xlsx
8. 520A-E January 1-2021 to 9-7-2021 DW-0085-Key Licensing Regulatory Compliance
9. OL Annual Checklist Compliance Determination Chart , FY 2021, dated 4.29.21
10. dbhds-risk-management-crosswalk-and-attestation-updated-8-2021
11. Crosswalk of DBHDS Approved Risk Management Training
12. 12VAC35-105- 160E
13. 12 VAC35-105-520.A
14. dehydration-pp-rat-10.2020
15. falls-pp-rat-10.2020
16. seizures-pp-rat-10.2020
17. aspiration-pneumonia-pp-rat-10.2020
18. constipation-and-bowel-obstructions-pp-rat-10.2020
19. dehydration-pp-rat-10.2020
20. Summary of Training and Resources on Individual Risk Level Screening
21. Bi-Annual Report to RMRC, Health and Safety Alerts.December2020
22. RMRC Minutes June 15, 2020
23. Bi-Annual Report to RMRC: Health and Safety Alerts, June 2020
24. RMRC Minutes 12.21.2020_Approved
25. RMRC Minutes 6.21.2021 Approved
26. Summary of Guidance on Conducting Root Cause Analysis.docx
27. Assessment of Providers Conducting RCA.docx
28. Final-licensing-regulations-october-2020-training
29. Guidance on Corrective Action Plans – effective 8/22/20
30. Risk Management & Quality Improvement Strategies – CDDER – December 2020
31. Final Licensing Regulations presentation – October 2020
32. Guidance for a Quality Improvement Program (November 2020)
33. Guidance for Serious Incident Reporting, 11/28/20.
34. Questions and Answers from QI-RM-RCA Training November 2020 (January 2021)
35. Risk Management Quality Improvement Tips and Tools (June 2021)
36. DOJ Settlement Agreement – Process Document, 8/2/21
37. 12VAC30-120-990(A)
38. 12VAC30-10-10
39. Quality Review Team (QRT) 2020 EOY Report to the QIC
40. QRT Process for Notice and Review of the QRT EOY Report
41. CSB QRT SurveyMonkey Questionnaire
42. Approved AppH_7-1-21
43. Appendix H Continuation in Waiver Application_7-1-21
44. Waiver Application for 1915c HCBS VA.0372.R04.07_07.01.21.
45. FINAL DRAFT QRT Year End Report 6 2020 v 6_3 2021
46. REVISED FINAL QRT Charter 2021
47. FINAL FY 19 2020 4 Qtr QA Measures QRT Char
48. REVISED FINAL DRAFT 2020 QRT Year End Report 9 2021
49. FY2021 3rd Quarter QRT Meeting Agenda, 8/18/21

50. FY 2021 3rd Qtr. QRT Meeting Summary, 51/9/21
51. FINAL FY 19 2020 4 Qtr QA Measures QRT Chart
52. Data Quality Monitoring Plan: Annual Update Process, April 2021
53. Data Quality Monitoring Plan Source System Annual Update, dated June 2021
54. Data Quality Monitoring Plan: Reassessment with Actionable Recommendations, dated June 2021
55. CMSC which QII draft 4.2.21
56. QII Tool_RMRC Decision March 2021
57. KPA PCC - which QII 5.21.21
58. RMRC QII Discussion Outline 4.9.2021
59. RMRC QII Ranking – final 4.29.2021
60. RMRC QII Tool - Which problem to focus on 2.19.2021
61. QII Toolkit SFY21 final template Nov 2020
62. QII Toolkit FY22_final template 7.23.2021
63. DBHDS QIC presentation NCI June 28, 2021 (Using Virginia's NCI Data)
64. KPA Workgroups Dental PDSA as of 8.26.2021
65. KPA Workgroups ECT Services PDSA as of 8.27.202
66. MRC COVID-19 PDSA as of 8.24.2021
67. PDSA Employment Outcomes RQC5 as of 8.31.2021
68. RMRC Med Errors PDSA as of 8.25.2021
69. RQC1 IHS PDSA as of 8-20-21
70. Falls PDSA Worksheets as of 8.30.2021
71. SFY21 Completed RQCs QIC Subcommittee Work Plan ending 6.30.21
72. SFY21 Completed CMSC QIC Subcommittee Work Plan ending 6.30.21.
73. SFY21 Completed KPA Workgroup QIC Subcommittee Work Plan ending 6.30.21
74. Completed MRC QIC Subcommittee Work Plan ending 6.30.21
75. SFY21 Completed RMRC QIC Subcommittee Work Plan ending 6.30.21
76. CMSC which QII draft 4.2.21
77. QII Tool RMRC Decision March 2021
78. KPA PCC - which QII 5.21.21
79. RMRC QII Discussion Outline 4.9.2021
80. RMRC QII Ranking – final 4.29.2021
81. RMRC QII Tool - Which problem to focus on 2.19.2021
82. QII Toolkit SFY21 final template Nov 2020
83. QII Toolkit FY22_final template 7.23.2021
84. DBHDS QIC presentation NCI June 28, 2021 (Using Virginia's NCI Data)
85. KPA Workgroups Dental PDSA as of 8.26.2021
86. KPA Workgroups ECT Services PDSA as of 8.27.202
87. MRC COVID-19 PDSA as of 8.24.2021
88. PDSA Employment Outcomes RQC5 as of 8.31.2021
89. RMRC Med Errors PDSA as of 8.25.2021
90. RQC1 IHS PDSA as of 8-20-21
91. Falls PDSA Worksheets as of 8.30.2021
92. SFY21 Completed RQCs QIC Subcommittee Work Plan ending 6.30.21
93. SFY21 Completed CMSC QIC Subcommittee Work Plan ending 6.30.21.
94. SFY21 Completed KPA Workgroup QIC Subcommittee Work Plan ending 6.30.21
95. Completed MRC QIC Subcommittee Work Plan ending 6.30.21
96. SFY21 Completed RMRC QIC Subcommittee Work Plan ending 6.30.21
97. Draft QIC Minutes June 28, 2021
98. 4th QTR CMSC Report to the QIC June 28, 2021
99. 4th QTR KPA Workgroups Report to the QIC.
100. 4th QTR MRC Revised Report to the QIC June 28, 2021

101. 4th QTR RMRC Report to the QIC June 28, 2021
102. 4th QTR RQCs Report to the QIC June 28, 2021
103. CMSC Report FY 21 1st and 2nd Qrt_3.22.21 final (updated 5.3.21
104. DBHDS QIC presentation NCI June 28, 2021
105. DOJ-FY21_2nd Qtr RST Report_3.2021_final
106. Glossary of Acronyms Used in QIC Meetings
107. QIC Meeting June 2021 Agenda
108. QRT 2020 EOY Report Presentation to QIC 6 28 2021
109. Draft QIC Minutes June 28, 2021
110. RMRC Agendas 7/2020-6/2021
111. RMRC Data Workgroup Notes 9/2020-6/2021
112. Falls Workgroup Notes 10/2020-6/2021
113. PDSA Review _working doc update 2.17.2021
114. Approved RMRC Minutes 7/2020-6/2021
115. Medication Error Discussion_040221
116. UTI Work Group Meeting Feb 10 2021
117. UTI Work Plan 10.15.2020
118. Approved DBHDS MRC Meeting Minutes 10/8/20-9/24/21
119. MRC Data Report_ Final, Quarters 1-4 2021
120. Ten Measures Rates - 02-04 SFY 2020 - 09212020.pdf
121. RMRC Work Group Updates for 11.16.2020
122. Serious Incident Data Update -11.16.2020
123. Surveillance Measures Update -11.16.2020
124. Surveillance Measures Update - 2021.02.22.
125. SIS Level Update 11.16.2020
126. OHR DD Exploitation Overview 2.22.21
127. Serious Incident Data Update - 2021.02.22
128. UTI Study Report to RMRC_2.22.2021
129. RMRC Work Group Updates for 1.25.2021
130. Work Group Updates RMRC 2.22.2021
131. Work Group Updates RMRC 3.15.2021
132. Work Group Updates RMRC 4.19.2021
133. Abuse, Neglect, and Exploitation Data - 2021.03.15
134. RMRC 02 FY21 CLB 3.15.21
135. IMU RMRC April 19 2021
136. Recommendations from UTI Workgroup 5.14.2021
137. RMRC OHR 5.17.21
138. SEVTC Risk Management Review Committee 51721
139. Surveillance Measures Update - 2021.05.17
140. Work Group Updates RMRC 5.17.2021
141. Abuse, Neglect, and Exploitation Data - 2021.06.21
142. OIH-OL Report to RMRC Med Errors PP 6.21.2021
143. OL Report to RMRC QI-RM 6-9-2021
144. RMRC Q3 FY21 CLB 6.21.21
145. UTI Mitigating Strategies 6.21.2021
146. Work Group Updates RMRC 6.21.2021
147. CMSC Meeting Agenda 03.02.2021
148. Approved DBHDS MRC Meeting Minutes 03.11.2021
149. Approved DBHDS MRC Meeting Minutes 03.25.2021
150. QII Toolkit SFY21 final template Nov 2020
151. QII Toolkit FY22_final template 7.23.2021

152. KPA Workgroups Dental PDSA as of 8.26.2021
153. KPA Workgroups ECT Services PDSA as of 8.27.202
154. MRC COVID-19 PDSA as of 8.24.2021
155. PDSA Employment Outcomes RQC5 as of 8.31.2021
156. RMRC Med Errors PDSA as of 8.25.2021
157. RQC1 IHS PDSA as of 8-20-21
158. Falls PDSA Worksheets as of 8.30.2021
159. QII Tool RMRC Decision March 2021
160. KPA PCC - which QII 5.21.21
161. RMRC QII Discussion Outline 4.9.2021
162. RMRC QII Ranking – final B 4.29.2021
163. RMRC QII Tool - Which problem to focus on 2.19.2021
164. CMSC Data Work Group Agenda notes 1/15/21-8/18/21 (eight sets)
165. Agenda SCQR Workgroup notes 1/15/21-6/9/51 (five sets)
166. SFY21 Completed RQCs QIC Subcommittee Work Plan ending 6.30.21
167. SFY21 Completed CMSC QIC Subcommittee Work Plan ending 6.30.21.
168. SFY21 Completed KPA Workgroup QIC Subcommittee Work Plan ending 6.30.21
169. Completed MRC QIC Subcommittee Work Plan ending 6.30.21
170. SFY21 Completed RMRC QIC Subcommittee Work Plan ending 6.30.21
171. Technical Guidance for Measure Development, 7/26/21
172. 37 PMIs PDF files:
    a. Annual 2% increase in individuals receiving integrated services Last Updated 6.9.21
    b. CTH identifies a community residence within 30 days of admission Last Updated July 2020
    c. Individuals are involved in the community without barriers Last Updated 2.25.21
    d. ISPs are implemented appropriately Last Updated 2.25.21
    e. People with DD waivers are supported by trained, competent DSPs Last Updated 6.9.21
    f. Regulatory requirements of QI programs Updated 8.12.21
    g. Risk Incident Monitoring Rates Last Updated 7.22.21
    h. RST timeliness of 5 beds or more referrals Last Updated 2.25.21
    i. 90% of new waiver individuals receive integrated services Last Updated 6.9.21
    j. CEPPs are completed within 15 days Last Updated 6.29.21.
    k. Choice among providers, including Support Coordinator Last Updated 2.25.21
    l. Corrective actions for substantiated ANE are implemented Last Updated 2.24.21
    m. Critical incidents are reported on time Last Updated 2.24.21
    n. Data Summary shows an increase in services available by locality Last Updated 6.9.21
    o. Individuals are involved in the community with the most integrated support Last Updated 2.25.21
    p. Individuals are working for 12 months or longer Last Updated 8.9.21
    q. Individuals have community engagement goals Last Updated 6.9.21
    r. Individuals have relationships and interactions with people Last Updated 2.25.21
    s. Individuals have stability in independent housing Last Updated 2.25.21
    t. Individuals live in independent housing Last Updated 2.25.21
    u. Individuals meeting ECM criteria receive F2F visits every other month in their residence 5.20.20
    v. Individuals meeting ECM criteria receive F2F visits every other month Last Updated 8.6.21
    w. Individuals on the DD waivers will have a documented annual physical exam date July 2020.
    x. Individuals on the DD waivers will have actual annual physical exam date. July 2020.
    y. Individuals who chose or had some input in choosing where they live 5.20.20
    z. ISPs are modified based on assessed needs Last Updated 2.25.21
    aa. ISPs contain employment outcomes Last Updated 6.9.21
    bb. Provider investigations of abuse and neglect allegations are conducted Last Updated 6.9.21
    cc. Regulatory requirements of QI programs Last Updated 9.18.2020.

dd. Regulatory requirements of RM programs Last Updated 9.18.20.
ee. Regulatory requirements of RM programs 8.12.21
ff. RST timeliness of non-emergency referrals Last Updated 2.25.21
gg. Seclusion or restraints only utilized after less restrictive interventions Updated 2.19.2021
hh. State policies and procedures for the use or prohibition of seclusion Last Updated 2.24.21
ii. Teen employment discussion Last Updated 7.22.21.
jj. Transportation (excluding NEMT) is provided to facilitate participation in community activities Last Updated 7.6.21
kk. Unexpected deaths, where the cause of death Last Updated 3.3.21

185. Quality Improvement Committee, SFY 21 Q4
186. KPA Workgroups Final Agenda January 28, 2021
187. KPA Workgroups Final Agenda February 25 2021
188. Approved KPA Workgroup minutes March 25, 2021
189. Approved KPA Workgroup Minutes April 22, 2021
190. Approved KPA Workgroups minutes June 24, 2021
191. SFY21 KPA Schedule Surveillance Data Updated Dec 2020
192. SFY22 KPA Workgroups Schedule Overall and Surveillance Data
193. Domain and Surveillance Report 7.24.2020.
194. DBHDS QIC presentation NCI June 28, 2021
195. VA NCI Project infographic 2019-2020 (VCU)
196. NCI FY19-20 Report Review for KPA Workgroups, June 24.2021
197. Virginia NCI behavior snapshot 2019
198. Using Virginia's NCI Data: National Core Indicators In-Person Survey
199. RQC QIC Approved QIIs as of December 14, 2020
200. Master RQC Attendance FY2021 Updated 6.15.2021
201. SFY21 Approved Revised Regional Quality Council Charter 12.20
202. FY21 Approved Regional Quality Council Charter 9.21.2020
203. Final RQC Membership and Orientation Process Flow
204. MQ for DATA VERIFICATION_RQC Training Log Source System 8.27.2021
205. Orientation Handout GENERIC 04022021
206. Orientation Handout-FULL 03072020
207. RQC Orientation Data FY21Q4 6.22.2021
208. RQC Training Modules April 2021
209. FY21-Q1 APPROVED Minutes 8.10.2020 for five RQCs
210. FY2021 Quarter 2 RQC Minutes
211. FY2021 Quarter 3 RQC Minutes
212. FY2021 Quarter 4 RQC Minutes
213. RQC 1st QTR FY21 Report to the QIC 9.21.2020
214. RQC 2nd QTR Report to QIC 12-14-20
215. RQC 3rd QTR Report to the QIC 3-22-2021
216. 4th QTR RQCs Report to the QIC June 28, 2021
217. SFY21 Completed RQCs QIC Subcommittee Work Plan ending 6.30.21
218. RCQ5 Employment Outcome Survey Responses September 27, 2021
219. RQC5 Employment Outcomes QII Status Update September 27, 2021
220. September 27 2021QIC presentation materials
221. Provider Data Summary Semi-Annual Report State Fiscal Year 2020-2021, 5/1/21-10/31/20
222. http://dojsettlementagreement.virginia.gov/
223. https://dbhds.virginia.gov/
224. DOJ Settlement Agreement Library Protocol, June 30, 2020
225. DW-0097, 1/1/21through 3/31/21
226. DW-0097, 4/1/21 through 6/30/21

227. Protocol for the Identification and Monitoring of Individuals with Complex Behavioral, Health, and Adaptive Support Need sand the Development of Corrective Action Plans required to Address Instances Where the Management of Needs for These Individuals Falls Below Identified Expectations for the Adequacy of Management and Supports Provided, May 29, 2020.
228. Concept Report Template to the QIC, September 27, 2021

APPENDIX I

LIST OF ACRONYMS

ADL	Activities of Daily Living
APS	Adult Protective Services
ADA	Americans with Disabilities Act
AR	Authorized Representative
AT	Assistive Technology
BCBA	Board Certified Behavior Analyst
BSP	Behavior Support Professional
CAP	Corrective Action Plan
CAT	Crisis Assessment Tool
CEPP	Crisis Education and Prevention Plan
CHRIS	Computerized Human Rights Information System
CIL	Center for Independent Living
CIM	Community Integration Manager
CI	Compliance Indicator
CIT	Crisis Intervention Training
CL	Community Living (HCBS Waiver)
CM	Case Manager
CMS	Center for Medicaid and Medicare Services
COVLC	Commonwealth of Virginia Learning Center
CPS	Child Protective Services
CRC	Community Resource Consultant
CSB	Community Services Board
CSB ES	Community Services Board Emergency Services
CTH	Crisis Therapeutic Home
CTT	Community Transition Team
CVTC	Central Virginia Training Center
DARS	Department of Rehabilitation and Aging Services
DBHDS	Department of Behavioral Health and Developmental Services
DD	Developmental Disabilities
DDS	Division of Developmental Services, DBHDS
DMAS	Department of Medical Assistance Services
DOJ	Department of Justice, United States
DS	Day Support Services
DSP	Direct Support Professional
DSS	Department of Social Services
DW	Data Warehouse
ECM	Enhanced Case Management
EDCD	Elderly or Disabled with Consumer Directed Services
EFAG	Employment First Advisory Group
EPSDT	Early and Periodic Screening Diagnosis and Treatment

ES	Emergency Services (at the CSBs)
ESO	Employment Service Organization
FRC	Family Resource Consultant
GH	Group Home
GSE	Group Supported Employment
HCBS	Home- and Community-Based Services
HPR	Health Planning Region
HR/OHR	Office of Human Rights
HSN	Health Services Network
IADL	Individual Activities of Daily Living
ICF	Intermediate Care Facility
ID	Intellectual Disabilities
IDD	Intellectual Disabilities/Developmental Disabilities
IFDDS	Individual and Family Developmental Disabilities Supports ("DD" waiver)
IFSP	Individual and Family Support Program
IR	Independent Reviewer
ISE	Individual Supported Employment
ISP	Individual Supports Plan
ISR	Individual Services Review
KPA	Key Performance Areas
LIHTC	Low Income Housing Tax Credit
MLMC	My Life My Community (website)
MOU	Memorandum of Understanding
MRC	Mortality Review Committee
NVTC	Northern Virginia Training Center
ODS	Office of Developmental Services
OHR	Office of Human Rights
OIH	Office of Integrated Health
OL	Office of Licensing
OSIG	Office of the State Inspector General
PASSR	Preadmission Screening and Resident Review
PCR	Person Centered Review
PCP	Primary Care Physician
PHA	Public Housing Authority
POC	Plan of Care
PMI	Performance Measure Indicator
PMM	Post-Move Monitoring
PST	Personal Support Team
QAR	Quality Assurance Review
QI	Quality Improvement
QIC	Quality Improvement Committee
QII	Quality Improvement Initiative
QMD	Quality Management Division
QMR	Quality Management Review
QRT	Quality Review Team

QSR	Quality Service Reviews
RAC	Regional Advisory Council for REACH
REACH	Regional Education, Assessment, Crisis Services, Habilitation
RFP	Request For Proposals
RNCC	RN Care Consultants
RST	Regional Support Team
RQC	Regional Quality Council
SA	Settlement Agreement US v. VA 3:12 CV 059
SC	Support Coordinator
SELN AG	Supported Employment Leadership Network, Advisory Group
SEVTC	Southeastern Virginia Training Center
SIR	Serious Incident Report
SIS	Supports Intensity Scale
SW	Sheltered Work
SRH	Sponsored Residential Home
START	Systemic Therapeutic Assessment Respite and Treatment
SVTC	Southside Virginia Training Center
SWVTC	Southwestern Virginia Training Center
TC	Training Center
VCU	Virginia Commonwealth University
VHDA	Virginia Housing and Development Agency
WaMS	Waiver Management System