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, 2022 – September 30, 2022

Respectfully Submitted By

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Independent Reviewer
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I. EXECUTIVE SUMMARY

This is the Independent Reviewer's twenty-first 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 past year with a primary focus on the Twenty-first Review Period, April 1, 2022 – September 30, 2022.

Throughout this time, the health threats and other negative impacts of COVID lingered. Virginia's providers still struggled to recruit and retain essential workers, a challenge that preceded and was exacerbated by the pandemic. Some families were reluctant to have their family members spend their days in congregate settings with large numbers of people in close proximity. Due to staff shortages, some providers consolidated, reduced or ceased program operations altogether. These factors contributed to the ongoing decline in participation by individuals with DD waiver-funded services in the full range of day programs. Commendably, although still below the pre-pandemic level, Fiscal Year 2022 saw an increase in the number of individuals with IDD who were employed.

During the past year, the Commonwealth continued to implement and strengthen its monitoring processes that confirm the adequacy and quality of CSB and provider services. DBHDS's Offices of Licensing and Human Rights largely achieved the Agreement's applicable requirements for monitoring providers to ensure they reached at least the minimum standards required for regulatory compliance. The QSR process was also improved, with QSR reviewers' determinations aligning more closely with those of the Independent Reviewer's consultants.

However, although DBHDS's Quality Service Review (QSR) process and quarterly case management onsite assessments were strengthened, they both still remained inadequate. These processes were not properly implemented to make sure services for individuals were of good quality and appropriately delivered or modified as needed. The effectiveness of these two external monitoring processes are critical to Virginia's system-wide ability to identify the most serious concerns that interfere with meeting the needs of those at the heart of the Agreement. Without adequate identification, the Commonwealth cannot address and resolve service problems, many of which have far reaching and negative consequences.

DBHDS's Quality Improvement Committee (QIC) and Regional Quality Councils (RQCs) are increasingly fulfilling the structural functions required by the Agreement. It is worth emphasizing, though, that when Virginia's monitoring systems fail to detect individual and system-wide issues, or do not report reliable and valid data, the RQCs and the QIC cannot respectively identify and target quality improvement initiatives to fix major obstacles to the service system and its desired outcome: meeting individuals' needs.

For example, this Period's review found that DBHDS's QSR process did not detect a majority of the service inadequacies for the individuals with complex medical support needs who were studied. When these individuals did not receive sufficient authorized nursing services, or when some service plans did not identify critical service needs or assessments, the QSR process did not highlight these outcomes as a concern. To its credit, the Department reviewed related findings following a similar Twentieth Period study, and designed and implemented improvements for its subsequent round of the QSR process. (This is now underway, and will be reviewed as part of a future Report.)

Virginia implemented a number of effective steps to improve data integrity during this Period and newly met seven data related Compliance Indicators. Although it is working to remediate other data problems, the Commonwealth frequently did not verify and attest to the reliability and validity of the data it reported to demonstrate its achievement of several Indicators. In other instances, Virginia did not remediate the substantive reliability and validity problems identified in its previous assessments, or failed to explain how it addressed and resolved these problems. Because reliable and valid data are the fuel for an effective quality and risk management system, the functionality of the Commonwealth's quality assurance framework continued to be severely hampered by this lack.

Overall, Virginia made concerted efforts and progress that resulted in newly meeting 24 Indicators. However, since 16 of these achievements were based on reported data that the Commonwealth had not verified as reliable and valid, these determinations are conditional (i.e., met*).

In summary, for the Twenty-first Review Period, Virginia maintained Sustained Compliance with 22 Provisions. The Commonwealth also achieved Compliance with one Provision for the first time (V.G.3 – assessment of the adequacy of supports), and made other notable improvements: of the 180 Indicators reviewed, Virginia met, either fully or conditionally, a total of 127 (71%), compared with 101 (56%) of these same 180 Indicators previously. Of the 76

Indicators that it had not met previously in any form the Commonwealth, as mentioned above, fully or conditionally achieved 24 of these Indicators (32%) for the first time.

Virginia deserves commendation for its ongoing diligence and new initiatives designed to improve existing services and quality assurance systems. However, the Commonwealth must continue to strengthen its oversight and monitoring systems to improve the adequacy and availability of services, especially for those individuals with complex behavioral and/or medical support needs. To achieve such improvements, Virginia should accurately identify systemic shortcomings in its quality monitoring processes. The Commonwealth should also undertake further well-targeted and measurable quality improvement initiatives, and prioritize addressing and resolving its data integrity issues.

In closing, it is important to reiterate the underlying purpose of the Consent Decree. The Indicators specifying structural and functional aspects of Virginia's system operate in service to other Indicators that measure outcomes for individuals with IDD. It is these outcomes, rather than the structural inputs, that can ultimately achieve the Agreement's three stated goals: community integration, self-determination and quality services.

II. DISCUSSION OF COMPLIANCE FINDINGS

A. Methodology

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

- Services for Individuals with Complex Medical Needs;
- Quality and Risk Management;
- Provider Training;
- Quality and Improvement Programs;
- Integrated Day Activities and Supported Employment;
- Transportation;
- Regional Support Teams;
- Mortality Review;

- Office of Licensing and 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 ten 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 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 sets 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 Twenty-first 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 previously achieved during consecutive reviews.

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 make sufficient documentation available that would:

- "Prove its Case" for having achieved all Indicators for the Provisions being studied, and
- Supply its records to document that each of its data sets for the Provisions being studied provide reliable and valid data for compliance reporting.

To determine any ratings of Compliance for the Twenty-first Review Period, the Independent Reviewer considered information delivered by the Commonwealth prior to October 15, 2022, and responses to consultant requests for clarifying information up to November 13, 2022. 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 submitted to the Parties under seal.

For each study, the Commonwealth was asked to make its records available that document the proper implementation of the Provisions and the associated Compliance Indicators being reviewed. For each Indicator with a function or performance measure that utilized reported data, Virginia must make available its completed *Process Document* and *Attestation*. With these two documents, the Commonwealth asserts that each of its reported data sets has been verified as reliable and valid. If Virginia performs functions using reported data that have not been verified, or if the Commonwealth submits data that show an Indicator's performance measure has been achieved, but either of these two documents was not delivered, was incomplete or otherwise insufficient, then the Independent Reviewer will determine that Virginia has "met*" the Indicator. This met* rating is not final and cannot be used for Compliance determinations, but rather is for illustrative purposes only.

Information that was not supplied for the studies was not considered in the consultants' reports or in the Independent Reviewer's findings and conclusions. If the Commonwealth did not provide sufficient documentation, the Independent Reviewer determined that it had not demonstrated achievement of the associated Compliance Indicator.

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 Twenty-first Report to the Court.

B. Discussion of Compliance Findings

1. Services for Individuals with Complex Medical Support Needs

Background

For the Eighteenth Review Period, an Individual Services Review (ISR) study was undertaken to identify the extent to which any possible discrepancies existed in the Commonwealth's Quality Service Reviews (QSR) findings related to serving individuals with IDD who have complex medical support needs. The Independent Reviewer had selected the following components of two Compliance Indicators associated with Provisions V.I.1. and V.I.2. for review:

- "Providers keep service recipients safe from harm, and access treatment for service recipients as necessary" (Indicator 51.4 c.);
- "Individuals' needs are identified and met, including health and safety consistent with the individual's desires, informed choice and dignity of risk" (Indicator 52.1 a.); and
- "Services are responsive to changes in individual needs (where present) and service plans are modified in response to new or changed service needs and desires to the extent possible" (Indicator 52.1 c.)

The cohort for this ISR study was the 99 individuals who were living in HCBS waiver-funded sponsored or group home residential services, whose Supports Intensity Scale (SIS) evaluation results placed them in level six, and whose services were evaluated during the Person-Centered Review (PCR) portion of DBHDS's 2020 QSR study.

For the selected random sample of individuals (34), the ISR registered nurses' findings were compared with the QSR evaluators' findings. As a result of this comparative analysis, the status of Virginia's achievement of the QSR Indicators referenced above could be assessed.

DBHDS's QSR vendor's documentation of the 2020 QSR evaluations showed that the Commonwealth's service providers had met virtually all of the healthcare needs of a significant sample of all individuals with complex medical needs and waiver-funded sponsor or group home residential services. Based on the documents provided for review, however, this ISR study found that DBHDS's 2020 QSR evaluations failed to identify the vast majority of unmet healthcare needs for the individuals studied. For example:

- The ISR reviews identified nine of the 34 individuals (26.5%) who were not protected from potential risk of harm; whereas the QSR reviewers identified zero of 34 individuals (0%) was at potential risk of harm.
- The ISR reviews determined that 19 of the 34 individuals (55.9%) needed assessments or consultations that were not recommended or ordered; whereas the QSR reviewers identified one of 34 individuals (0.03%) who needed such assessments.
- The ISR reviews determined that 15 of the 34 individuals (44.1%) lacked access to dental care; whereas the QSR reviewers identified zero of 34 individuals (0.0%) needing this care.
- The ISR reviews did not find evidence that necessary lab tests were completed for seven of the 34 individuals (20.6%); whereas the QSR reviewers identified the lack of evidence of necessary lab tests for zero of 34 individuals (0.0%).
- The ISR reviews identified four of the 34 individuals (11.8%) whose ISPs required but were not modified; whereas the QSR consultants identified zero of 34 individuals' (0.0%) ISPs that were not modified as needed. Both reviews found the ISP for one individual had been modified as required.

As demonstrated by these points, the 2020 QSR PCR assessments erroneously determined that the Commonwealth's providers met virtually all the healthcare needs of the individuals studied. This conclusion substantially compromised Virginia's ability to fulfill the Indicator requirements and the fundamental purpose of its QSR study: to produce valid and reliable information that can be used to improve practice as well as the quality of services on the provider, CSB, and system-wide levels.

As a result, the Commonwealth did not meet the three components of the two relevant QSR Compliance Indicators: Provision V.I.1.'s Indicator 51.4 c., and Provision V.I.2.'s Indicator 52.1 (a. and c.). Virginia therefore remained in Non-Compliance with these Provisions.

Twenty-first Period Study

For the latest review, the Independent Reviewer retained the same consultants to assess to what extent discrepancies still existed in the QSR system, again related to serving individuals with complex medical support needs. The same three components of the two Compliance Indicators were selected for review, namely 51.4 c., 52.1 a. and 52.1 c.

The cohort for this ISR study was 57 individuals whose SIS placed them in level six, and whose services were evaluated during the PCR portion of DBHDS's 2021 QSR study. From this cohort,

a random sample of 32 individuals was selected for review. This number allowed the study's findings to be generalized to the cohort.

In some instances, however, DBHDS failed to provide sufficient records for all 32 individuals. In addition, although most residential contacts interviewed were knowledgeable about the individual, some had difficulty answering questions with accuracy or sufficient detail. Therefore, it is possible that certain identified discrepancies in the respective findings were not actual discrepancies, but rather the result of inconsistent sources of information.

For the selected random sample of individuals (up to 32), the ISR registered nurses' findings were compared with the QSR evaluators' conclusions. Overall results this time showed improvement from the Eighteenth Period review, but QSR auditors still failed to detect the majority of the following unmet needs:

- Of the seven individuals who needed assessments or consultations; the QSR did not identify six (86%);
- Of the five individuals' ISPs that needed modification, the QSR did not identify two ISPs (100%) that had not been modified;
- Of the 15 individuals who needed dental care, the QSR did not identify 11 (73%); and
- Of the six individuals who received nursing services, the QSR^ did not identify four (67%) who received less than 80% of the authorized hours.

^ The current QSR process does not consider if, and the extent to which, needed nursing services are received when it determines whether individuals' health and safety needs have been met.

On a positive note, the ISR study agreed with the QSR review that ten of the 32 individuals had no unmet healthcare needs. This suggests progress: that the Commonwealth's service providers were addressing the healthcare needs of a larger percentage of the individuals studied.

See Appendix A for the consultants' full report.

Conclusion

Regarding Provision V.I.1.'s Indicator 51.4 c., and Provision V.I.2.'s Indicator 52.1 (a. and c.), Virginia did not achieve these Indicators, and therefore remains in Non-Compliance with these Provisions.

2. 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.

In 2020, DBHDS's documentation acknowledged that its data reliability issues had continued, and that concerns previously identified in its assessments had not been remedied. The Seventeenth Period review determined that, despite these ongoing data reliability and validity problems, the Department's intensified management focus had led to the achievement of 12 of the 50 QRM Indicators for the first time.

The following year, the Nineteenth Period study found a significant delay in DBHDS's production of the requested documents and in the arrangement of interviews. In spite of this, the Department collected considerable data from various sources and took steps to improve data quality, but did not sufficiently address the findings and recommendations of its own assessments in eight of the twelve previously studied source systems. It had not remedied the substantive reliability and validity problems, 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.

This 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 (QI) initiatives, and to fulfill its own commitment to continuous quality improvement.

It is important to note that in June 2021, DBHDS produced its *Data Quality Monitoring Plan – Reassessment and Actionable Recommendations* (Plan). Although this Plan was promising, it did not include an estimated time frame for the Department to find that its data sources provide reliable and valid data.

The Nineteenth Period study concluded that the Commonwealth had met* 29 of the 50 Compliance Indicators for the five QRM Provisions, V.C.4., V.D.1., V.D.2.a.-d., V.D.3. and V.D.4. This compared with having met just 12 of these Indicators during the previous review. Virginia therefore remained in Non-Compliance with each of these Provisions.

Twenty-First Period Study

For this latest review, the Independent Reviewer retained the same consultant to assess the status of the Commonwealth's QRM System. Overall, Virginia continued to work diligently, and achieved or met* 11 more Indicators than in the Nineteenth Period. However, the Commonwealth did not always complete the required *Process Document* and accompanying *Attestation* for each data set reported. Also, when these documents were provided, they did not consistently identify, isolate and address the previously identified threats to data reliability and validity deficiencies in the data source systems and data sets. Again, this lack of valid and reliable data permeated and impacted the findings for most Twenty-first Period studies.

Summarized below are four of the five QRM Provisions whose associated Indicators were newly achieved or met* during this Period, and the reasons for such determinations. The Indicators that Virginia did not meet related to the lack of ability of its providers, Regional Quality Councils (RQCs) and the Quality Improvement Committee to dependably identify risks of harm and the key obstacles to delivering services of acceptable quality. This lack of ability undermines the Commonwealth's capacity to develop well-targeted QI initiatives, which is the central purpose of the Quality and Risk Management Section of the Settlement Agreement.

<u>Provision V.C.4.</u>

This Period's review examined the progress DBHDS 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 again continued its positive trend of expanding the availability of, and updates to, the training and guidance on these topics.

Virginia achieved Indicator 32.3 for the first time. The latest study confirmed that DBHDS required a Corrective Action Plan (CAP) whenever it determined that a provider is non-compliant with the Indicator's training-related risk management requirements.

Provision V.D.1.

Indicator 35.3 was met* for the first time. The Commonwealth established performance measures for each of the areas defined in the Indicator, as required and approved by CMS. Since no *Attestation* was provided, though, this achievement was conditional.

Indicator 35.6 was also achieved for the first time. Virginia implemented a much-improved method of assessing the competence of Direct Support Professionals (DSPs) and their supervisors. The study verified that the Commonwealth completed relevant annual financial audits as required.

A third Indicator, 35.8, was newly met* as well. The review confirmed that Virginia provided data showing that the 86% Indicator metric was achieved. However, the most recent data submitted was from Fiscal Year 2020. Also, the accompanying *Process Documents* and *Attestation* were incomplete, and the data set could not be verified as reliable and valid.

Provision V.D.2.a.-d.

The purpose of this Provision is to specifically ensure the consistent collection and analysis of reliable data. Although the Commonwealth reported data that showed it had achieved several of the QRM Indicators, often these data had not been verified as reliable and valid. Therefore, the met* findings below are conditional, and do not necessarily reflect progress toward achieving the central function of this Provision.

Indicator 36.4 was met* for the first time. The Risk Management Review Committee (RMRC), Case Management Steering Committee (CMSC) and Key Performance Area (KPA) workgroups all established goals and monitored progress through the creation of specific KPA Performance Measure Indicators (PMIs). But for many of the applicable data sets, DBHDS had not yet determined them to be reliable and valid.

Indicator 36.5 was also achieved for the first time. The Office of Data Quality and Visualization (DQV) revised its *Technical Guidance for Measure Development*, with the included guidance addressing the required elements.

A third Indicator, 36.6, was met* for the first time as well. DBHDS implemented a new approach that focused reporting on the KPA domain, including relevant PMIs from all applicable committees and workgroups, as well as National Core Indicators (NCIs) and QSR findings. This approach brought all this information together into one place, facilitating a comprehensive discussion. This well-thought out strategy holds promise: it enhances an interdisciplinary process for identifying areas of needed improvement at a systemic level, and for making and implementing recommendations to address them.

However, these functions require valid and reliable data as a foundation for accurate decision-making. As mentioned above, the data provided for this latest study could not be confirmed as valid and reliable.

Provision V.D.3.

Indicator 37.2 was met* for the first time. The review confirmed that the Quality Improvement Committee (QIC) workgroups had reported to the QIC on identified PMIs, outcomes and quality initiatives. The Office of DQV also reviewed PMIs at least annually, consistent with the processes required, including the identification of any threats to data reliability and validity. However, DBHDS had not completed *Process Documents* and *Attestations* for all data sets used in the PMIs.

The consultant also verified that Indicator 37.5 was newly met.* Each KPA workgroup completed the actions required. Although DBHDS achieved considerable progress in fully defining the methodology for collecting data for all PMIs, the Department had not determined its applicable data sets were reliable and valid.

Another Indicator, 37.6, was met* for the first time as well. DBHDS workgroups and committees had a process in place, reviewed the data on at least a semi-annual basis, and used this data to consider establishment of PMIs and/or QI initiatives. However, the data sets were not confirmed to be reliable and valid.

A fourth Indicator, 37.17, was also newly achieved. The Community Inclusion/Integrated Settings KPA workgroup finalized surveillance data to be collected for choice and self-determination.

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

Conclusion

The Twenty-first Period study concluded that the Commonwealth has met* 40 of the 50 Compliance Indicators for the five QRM Provisions, V.C.4., V.D.1., V.D.2.a.-d., V.D.3. and V.D.4., compared with having met* 29 of these Indicators during the Nineteenth Period's review.

Regarding Provision V.C.4.'s nine Indicators, 32.1–32.9, Virginia has met seven of them, namely 32.1–32.3, 32.5, 32.6, 32.8 and 32.9, but has not achieved the remaining two Indicators, 32.4 and 32.7. Therefore, the Commonwealth remains in Non-Compliance with this Provision.

Regarding Provision V.D.1.'s eight Indicators, 35.1–35.8, Virginia has met* five of them, namely 35.2, 35.3,* 35.4, 35.6 and 35.8,* but has not achieved the remaining three Indicators, 35.1, 35.5 and 35.7. Therefore, the Commonwealth remains in Non-Compliance with this Provision.

Regarding Provision V.D.2.a.-d.'s eight Indicators, 36.1–36.8, Virginia has met* five of them, namely 36.2,* 36.4,* 36.5, 36.6* and 36.7,* but has not achieved the remaining three Indicators, 36.1, 36.3 and 36.8. Therefore, the Commonwealth remains in Non-Compliance with this Provision.

Regarding Provision V.D.3.'s 24 Indicators, 37.1–37.24, Virginia has met* 23 of them, namely 37.1,* 37.2,* 37.3–37.4, 37.5*–37.6,* 37.8–37.9, 37.10,* 37.11, 37.12,* 37.13, 37.14,* 37.15, 37.16,* 37.17, 37.18,* 37.19, 37.20,* 37.21, 37.22,* 37.23 and 37.24,* but has not achieved the remaining Indicator 37.7. Therefore, the Commonwealth remains in Non-Compliance with this Provision.

Regarding Provision V.D.4., Virginia has not achieved the sole Compliance Indicator 38.1. Therefore, the Commonwealth remains in Non-Compliance with this Provision.

**Note*: Since DBHDS has not yet provided a fully completed *Process Document* and/or a signed *Attestation* asserting the reliability and validity of its data sets, ratings of "met*" are not yet final and cannot be used for Compliance determinations, but rather are for illustrative purposes only.

3. Provider Training

Background

Over the last several years, Virginia made 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 had developed, refined and delivered useful and effective training curricula to ensure that provider staff could be trained in the required knowledge and performance competencies. These included protecting the health, safety, and wellbeing of the individuals with IDD reliant on their support.

In time for the beginning of the Nineteenth Review Period, the new DMAS provider training regulations were finalized and became effective. However, the related findings of the Department's Quality Management Review (QMR) process, which did not use the new regulations as its basis for determination of regulatory compliance, were found to be inadequate, both in evaluation and generalization of its results. These involved whether all DSPs (Direct Support Professionals)/Supervisors, including contracted staff, actually met the training and core-competency requirements specified in Indicator 49.2.

For the Nineteenth Period study, DBHDS provided a final *Office of Licensing Guidance for a Quality Improvement Program* to describe how it ensured implementation of its final regulations. However, the Department did not submit evidence to show that its licensed providers, including CSBs, had completed any needed corrective action to address quality improvement plan deficiencies.

On a more encouraging note, DBHDS's Office of Licensing (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 licensing inspection procedures addressed in Indicators 49.8–49.12 were thorough. In addition, OL's Licensing Specialists demonstrated 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, were consistently presented at the Quarterly Provider Roundtable meetings as required by Indicator 49.13. Providers expressed their appreciation for these meetings and 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 were determined to be consistent with the requirements of Indicators 49.5, 49.7, and 50.1–50.3.

For the Nineteenth Review Period, Virginia met nine of the 13 Compliance Indicators associated with Provision V.H.1.: 49.1, 49.5–49.11 and 49.13, but did not achieve the four remaining Indicators: 49.2, 49.3, 49.4 and 49.12. The Commonwealth therefore remained in Non-Compliance with this Provision. Regarding Provision V.H.2., Virginia once again met the three associated Compliance Indicators: 50.1–50.3, and so maintained Sustained Compliance.

Twenty-first Period Study

To complete the Twenty-first Period study, the Independent Reviewer again retained the same consultant who had conducted past reviews of the status of the two Provider Training Provisions, V.H.1. and V.H.2., and their associated Indicators.

This latest review found that the Commonwealth had furthered its progress in executing a statewide core competency-based training curriculum. This included reliable oversight of provider implementation to ensure that DSPs and their Supervisors were competent in the elements of each Individual Supports Plan (ISP) for which they were responsible.

Virginia's efforts to develop, refine, and deliver useful and effective training curricula remained focused on ensuring that provider staff were trained in the knowledge and performance competencies required to exercise their job responsibilities. These included protecting the health, safety, and wellbeing of the individuals reliant on their support.

After a lengthy period of restricted in-person visits due to COVID, OL and DMAS's QMR program both resumed onsite inspections, as did DBHDS's Quality Service Reviews (QSRs). These increased the effectiveness of the Commonwealth's regulatory and quality oversight processes.

With revised waiver regulations now in place for more than a year, DBHDS and DMAS focused their primary attention on process refinement rather than initiation of new program requirements. Given the workforce challenges facing the provider community, this approach was warranted. Virginia evaluated its processes and procedures and made necessary refinements to more effectively improve its ability to achieve desired outcomes.

The most significant change related to the Commonwealth's oversight of its statewide core competency-based training curriculum and related requirements was the implementation of process changes described in Curative Action #10, which the Parties submitted to the Court in October 2021. These assigned responsibility for assessing providers' implementation of the training program with a more specifically designed assessment incorporated into DBHDS's QSR process. As part of this new approach, the QSR reviewers conducted onsite interviews, observations, and record reviews designed to better assess success of the relevant processes.

In June 2022, DBHDS's final aggregate report (for the third round of QSRs) was submitted. It included the first complete set of data using this expanded process and new methods, and results showed improvements over the previous process. Although this data set was available for analysis, DBHDS had not determined how to calculate Indicators' 49.3 and 49.4's performance measures. It did not provide data related to the estimated total numbers of the cohorts or the sizes of randomly selected samples of DSPs or DSP supervisors that would be sufficient to generalize its findings in order to determine achievement of this Indicator. The third round of QSRs evaluated only those DSPs and DSP supervisors whom providers had arranged to work during the scheduled QSR evaluation visits. Because this sample was not randomly selected, Virginia could not generalize its findings and report these data for compliance determinations. Future QSR evaluations should also specifically include identifying whether DSPs and their supervisors have not completed training and competency requirements, and that this cohort should only perform specific skills under the direct supervision and observation by qualified staff.

Licensing Specialists continued to carry out the Indicator requirements assessed through DBHDS's Licensing Inspection process. OL's *Annual Checklist Compliance Determination Chart – 2022* provided its Licensing Specialists with detailed instructions, including the evidence that must be assessed, how regulatory compliance is to be determined, and how non-compliance is to be documented in the annual licensing inspection Corrective Action Plan (CAP) documents generated from each inspection. Data related to the Licensing assessment of compliance with the regulations associated with Indicators 49.9–49.12 are recorded in the CONNECT data system.

DBHDS delivered provider-specific scoring for all licensed providers to the consultant for review. However, the Department did not provide an assessment of the CONNECT data system, nor a *Process Document* that explained findings on how any identified data integrity threats were addressed and resolved, nor how Virginia verified that the data sets provided for compliance reporting were reliable and valid. Without this information, the Independent Reviewer could not determine that the Commonwealth met the requirements of Indicator 49.12.

Overall, DBHDS continued its efforts to ensure that training and technical support was made available to its service providers across a variety of areas. These included nursing/health services and behavioral services. The Offices of Integrated Health and Provider Development continued their coordination of a multi-faceted support network for providers through newsletters, virtual and in-person training, health alerts, monthly nursing meetings, and quarterly provider roundtable meetings. Information from the ten sample providers interviewed as part of this study consistently praised the support provided by the Office of Integrated Health, and specifically commented on the utility of the *Health Trends* newsletter and the quarterly provider roundtable meetings.

See the consultant's full report in Appendix G.

Conclusion

Regarding Provision V.H.1.'s 13 Compliance Indicators, Virginia has met the requirements of nine of them, namely 49.1, 49.5–49.11 and 49.13. The Commonwealth did not achieve the remaining four: 49.2, 49.3, 49.4 and 49.12. Therefore, Virginia remains in Non-Compliance with this Provision.

Regarding Provision V.H.2.'s three Compliance Indicators, the Commonwealth has met all of them: 50.1–50.3, and has maintained Sustained Compliance once again.

4. Quality Service Reviews

Background

In the Agreement, Virginia committed to developing and implementing annual Quality Service Reviews (QSR) to ensure that its programs for individuals with IDD are of good quality, are protecting people from harm and are meeting the needs of those served. The completed QSR evaluations, which must be conducted consistent with a variety of Indicator requirements, provide information to DBHDS on improving practice and quality through the collection of valid and reliable data.

In 2015, the Independent Reviewer studied DBHDS's QSR vendor's tools and planned evaluation processes, and informed the Department that they were seriously flawed. Without substantially addressing these flaws, the vendor continued to conduct QSRs in Fiscal Years 2016

and 2017. In December 2017, the Independent Reviewer reported ongoing inadequacies in the QSR assessments: a lack of standards and definitions of terms for the review methodology, and that the QSR auditors were insufficiently qualified to make judgments related to the QSR's clinically driven inquiries and indicators regarding whether individuals' needs were being met. Unsuccessful efforts again in 2018 led the Commonwealth to select a new QSR vendor, and new rounds of QSRs began in January 2020. That same month, with Virginia not having achieved any of the three QSR Provisions, the Parties agreed to a set of 15 QSR-related Compliance Indicators.

DBHDS's new QSR vendor developed tools and methodology that were much improved. However, the Independent Reviewer pointed out several concerns: the minimum qualifications for its QSR auditors, as well as for its planned oversight and training, were insufficient. As well, the vendor's non-clinician QSR evaluators were unlikely to have the knowledge and insight to discern whether individuals' needs were identified and met.

For the QSR's aggregated results for Round 1 (2020) and Round 2 (2021), the Department did not determine whether the data produced were reliable and valid. In Curative Action #9 (dated November 19, 2021), the Parties agreed that the QSR process would also gather information related to provider Quality Improvement (QI) programs and specific performance measures. The Parties additionally agreed that these actions would not be considered operational until DBHDS found its QSR data sets provide reliable and valid data for compliance reporting.

At the conclusion of the vendor's second annual round in 2021, the Department determined that its QSR process and tools needed significant revisions to achieve the associated Indicators. These changes were finalized in time for implementation of QSR Round 3, which began in November last year. The changes looked promising, but because Round 3 had not yet been completed, the extent to which DBHDS's redesigned QSR process addressed and resolved the previously identified problems could not be determined.

The compliance findings in the Twentieth Report to the Court were based on the results from Round 2 and the plans for Round 3. The Twentieth Period review assessed five Indicators based on Round 3: the requirements for a pre-implementation communication plan (Indicator 51.3), the policies and outcomes related to the QSR contractor's staff (Indicator 52.6), whether those staff had training, knowledge, skills, and reviewer qualifications commensurate with what they were expected to review (Indicator 53.1), procedures for inter-rater reliability (Indicator 53.3), and training of QSR reviewers (Indicator 53.4).

The Twentieth Period study determined that the Commonwealth had met six of the 15 Indicators associated with the three QSR Provisions. For Provision V.I.1., Virginia had achieved one Indicator, 51.1, but had not met the remaining four Indicators, 51.2–51.5. For Provision V.I.2., the Commonwealth had achieved four Indicators, 52.3–52.6, and had not met the remaining two Indicators, 52.1–52.2. And for Provision V.I.3., Virginia met one Indicator, 53.1, but had not met the remaining three Indicators, 53.2–53.4. The Commonwealth therefore remained in Non-Compliance with these Provisions.

Twenty-first Period Study

For the latest review, the Independent Reviewer retained the same consultant to assess the status of Virginia's three QSR Provisions and their 15 associated Indicators. Since five Indicators (those related to Round 3 of the QSR process) – i.e., 51.3, 52.6, 53.1, 53.3 and 53.4 – were evaluated in the Twentieth Period study, this current Period's review focused on the remaining 11 Indicators that were not addressed at that time. The determinations below conclude the Commonwealth's status regarding all 15 Indicators in relation to Round 3.

In late 2021, the Parties agreed to two Curative Actions (#s 9 and 10) related to provider QI programs and staff competencies. For Round 3 of the QSR process, most of these evolving strategies were still in the early stages of implementation. They hold promise; however their success cannot be determined until DBHDS finds that its QSR process produces valid and reliable data sets for compliance reporting.

With the completion of Round 3, the latest study found that Virginia had again met the requirements of Provision V.I.1.'s Indicator 51.1 for an annual QSR implementation that results in every provider being sampled at least every two to three years.

For Indicator 51.2, the Commonwealth did not meet the requirements for in-person interviews and direct onsite observations due to COVID precautions. Indicators 51.4 and 51.5, as well as Provision V.I.2's Indicator 52.1 were also not met. This was because the Twentieth Period study, which identified specific deficiencies, was not completed before DBHDS began Round 3. These deficiencies related to the ability of QSR reviewers to identify potentially unmet clinical needs and to ensure access to treatment as necessary.

The latest qualitative studies, i.e., Provider Training and Individual Services Reviews (ISRs) also confirmed these QSR deficiencies. DBHDS still needs to improve its processes and QSR staff

training so that individuals' needs can be satisfactorily identified, access to needed treatment can be evaluated, and competent provider staff and QI programs can be ensured.

Provision V.I.2.'s Indicator 52.2 remained unmet. The Department still needed to advance how it utilizes information from the QSRs to improve practice and quality of services, to identify trends, and to address deficiencies at the provider, CSB, and system-wide levels. DBHDS's analysis was limited and it was often difficult to identify how the Department used QSR information in specific instances.

Indicators 52.3–52.5 were again met: DBHDS posted and shared the required information. However, as reported previously, the QSR vendor's recommendations to the Department's Quality Improvement Committee (QIC) were usually stated in broad and general terms, which made them challenging in informing QI efforts. This negatively impacted the ability of the QIC and its subcommittees to develop recommendations for meaningful practice and quality improvements.

Regarding Provision V.I.3., only Indicator 53.2 was evaluated in this study, since the remaining three Indicators were reviewed during the Twentieth Period. This latest study concluded that this Indicator was met for the first time, since 100% of providers have been reviewed in the past three rounds.

For several Indicators, the Commonwealth did not provide *Process Documents* and *Attestations* for the QSR data sets utilized to support compliance reporting.

Conclusion

The Twenty-First Period study determined that the Commonwealth has met seven of the 15 Compliance Indicators associated with the three QSR Provisions, V.I.1.–V.I.3.

Regarding Provision V.I.1.'s five Compliance Indicators, Virginia has met one of them, namely 51.1, but did not achieve the remaining four Indicators, 51.2–51.5. Therefore, the Commonwealth remains in Non-Compliance with this Provision.

Regarding Provision V.I.2.'s six Compliance Indicators, Virginia has met four of them, namely 52.3–52.6, but did not achieve the remaining two Indicators, 52.1–52.2. Therefore, the Commonwealth remains in Non-Compliance with this Provision.

Regarding Provision V.I.3.'s four Compliance Indicators, Virginia has met two of them, namely 53.1 and 53.2, but did not achieve the remaining two Indicators, 53.3–53.4. Therefore, the Commonwealth remains in Non-Compliance with this Provision.

5. Quality Improvement Programs

Background

The Agreement's three Provisions for Quality Improvement (QI) (i.e., V.E.1.–3.) focus on the requirement that all Training Centers, CSBs, and other community providers develop and implement a QI program, including root cause analyses, that are 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 individuals with IDD, since effectively implemented QI programs can address identified problems and resolve them in a timely manner. The Parties had agreed to these three Provisions and their 11 Compliance Indicators to guarantee that the essential elements, structure and expectations of the QI programs would be implemented, and that performance measures and reporting expectations would be established.

Highlights of the Nineteenth Period's study in 2021 were:

Provision V.E.1.

The Commonwealth finalized regulations that addressed each of Indicator 42.1's requirements. Virginia also met Indicator 42.2: 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 referenced the regulations that fulfill the Indicator requirements for review of serious injuries.

For this Provision's remaining three Indicators, 42.3–42.5, the Department did not assert that it had met the associated performance measures. The documentation provided was also unclear how DBHDS would calculate its performance to demonstrate achievement of the required measures. The Commonwealth therefore did not meet these Indicators, and so remained in Non-Compliance with this Provision.

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 from QI programs.

Virginia once again did not meet any of the four associated Indicators, 43.1–43.4, and so remained in Non-Compliance with this Provision. Subsequently, the Parties agreed to Curative Action #9 to address the requirements of Indicators 43.1 and 43.2.

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 study concluded that the Commonwealth did not meet either of this Provision's two Indicators, 44.1 and 44.2, and so remained in Non-Compliance.

Twenty-First Period Study

For the latest study, the Independent Reviewer retained the same consultant to review Virginia's progress toward achieving the three QI Provisions and their 11 associated Compliance Indicators.

Highlights from this study's findings are:

Provision V.E.1.

With DBHDS regulations and guidelines in place regarding providers' QI programs, the Commonwealth again met Indicators 42.1 and 42.2. For this review, the Department provided updated documentation that showed improvements to its guidelines.

Regarding Indicator 42.3, DBHDS reported 83% of providers were assessed for compliance in 2021, and 84% assessed during the first six months of 2022, falling just short of the required 86% performance measure. The Department's *Process Document*, *Attestation* and Performance Measure Indicator (PMI) template contained significant discrepancies regarding how these percentages are to be calculated. Since the metric for this Indicator was not met, and because DBHDS did not establish a consistent, verifiable calculation methodology for determining its own performance, Virginia did not achieve this Indicator.

For Indicator 42.4, DBHDS reported only 52% of providers were compliant in 2021 with these same regulations, and 54% during the first six months of 2022, falling well below the required 86% performance measure. Also, the Department did not provide evidence that non-compliant providers had implemented the required Corrective Action Plans (CAPs). Once again, the Commonwealth did not achieve this Indicator.

Virginia met Indicator 42.5 for the first time. DBHDS provided the required documentation showing that Training Centers' QI programs performed functions consistent with the requirements.

Provision V.E.2.

The Commonwealth yet again did not meet any of this Provision's four Indicators, 43.1–43.4.

For Indicators 43.1 and 43.2, Curative Action #9 requires DBHDS to gather information from the Quality Services Review (QSR) process during Round 3, and to continue to collect and report data for 12 surveillance measures. However, the Commonwealth agreed that this would not be operational until the Department found that its related QSR data was reliable and valid for compliance reporting. For this Period's report, DBHDS did not make this determination.

Regarding Indicator 43.3, the Department did not submit evidence that its Office of Data Quality and Visualization (DQV) had completed the required analysis of the community integration measure derived from the QSR data. DBHDS also did not provide a *Process Document* or an *Attestation* regarding the validity and reliability of the QSR data sets.

For Indicator 43.4, the Department made progress by defining provider reporting measures across all required domains. However, DBHDS did not review or analyze serious incident data for approximately one year.

Provision V.E.3.

Regarding Indicator 44.1, DBHDS submitted the required QSR Provider Quality Review (PQR) tool, but its questions, evaluation criteria and additional guidelines did not provide a clear procedure for addressing each of the specific criteria required by the Indicator for assessing and determining the adequacy of providers' QI programs.

In addition, the study identified other factors that negatively impacted the validity and reliability of the data collected in the QSR process. DBHDS also did not determine the validity and reliability of its QSR data sets.

For Indicator 44.2, the Department implemented a Consultation and Technical Assistance (CTA) pilot project to collect data from the Office of Licensing (OL) reviews that had identified DD providers with an approved CAP related to the applicable regulations. In addition, the QSR contractor issued QI plans to eight providers in the pilot project that included basic steps for the providers to take to address the identified deficiencies. Therefore, the Commonwealth achieved this Indicator for the first time. However, since DBHDS did not determine the validity and reliability of its QSR data sets, Virginia met* this Indicator only conditionally.

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

Conclusion

Regarding Provision V.E.1., the Commonwealth met three Compliance Indicators 42.1, 42.2 and 42.5, but did not meet the remaining two Indicators 42.3–42.4. Therefore, Virginia remains in Non-Compliance with this Provision.

Regarding Provision V.E.2., the Commonwealth once again did not meet any of the four associated Compliance Indicators, namely 43.1–43.4. Virginia therefore remains in Non-Compliance with this Provision.

Regarding Provision V.E.3.'s two Compliance Indicators, the Commonwealth again did not meet one of them, namely 44.1, but has met* the remaining Indicator 44.2.* Therefore, Virginia remains in Non-Compliance with this Provision.

**Note*: Since DBHDS has not yet provided a fully completed *Process Document* and/or a signed *Attestation* regarding its data reliability and validation, ratings of "met*" are not yet final and cannot be used for Compliance determinations, but rather are for illustrative purposes only.

6. Integrated Day Activities and Supported Employment

Background

DBHDS and the Department for Aging and Rehabilitative Services (DARS) had continued interagency collaboration on many projects to support participation of individuals with IDD in Individual Supported Employment and Group Supported Employment.

However, the Nineteenth Period review found that, despite these efforts, fewer individuals were involved in the Commonwealth's array of Supported Employment and other integrated day activity services than in earlier review periods. While DBHDS continued to demonstrate a strong commitment to individuals participating in these integrated service models, its ability to implement necessary activities to promote these services was curtailed during the pandemic. COVID restrictions were an important factor that contributed to this regression in participation. In addition to the impact of the pandemic, CSB case managers continued to demonstrate a lack of understanding of the purpose of Community Engagement's integration model, and of its importance and potential to help individuals to develop employment and related social skills. As COVID restrictions were reduced, case managers' effectiveness remained central to Virginia's ability to achieve its goals and meet the remaining associated Compliance Indicators.

Overall, the Commonwealth maintained Sustained Compliance with relevant 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. In addition, Virginia met the requirements of one of Provision III.C.7.a.'s ten Indicators (14.1), but did not achieve of any of the remaining nine Indicators (14.2–14.10). Also, the Commonwealth did not verify the reliability and validity of its reported data sets for these nine Indicators.

Twenty-first Period Study

For the latest review, the Independent Reviewer retained the same two consultants to assess the status of Virginia's Integrated Day Activities and Supported Employment service system. The focus of this study was to determine progress toward achieving the Indicators that the Commonwealth had not met previously, and to determine whether Virginia had sustained compliance with the Provisions already achieved.

Their review consisted of an extensive examination of documents related to the Commonwealth's efforts and current status, as well as interviews with DBHDS staff and

community stakeholders. The study's methodology also included a qualitative review of 98 Individual Support Plans (ISPs) to determine if case managers fulfilled the relevant Indicators' requirements. These include meaningful discussions with individuals and their authorized representatives regarding community engagement and employment services, and setting employment goals. Additionally, a process was conducted to review and verify that Virginia's documents and compliance reports included reliable and valid data sets.

In general, although the impacts of the pandemic lingered, DBHDS made progress toward accomplishing some of the Indicator performance measures, it regressed with others. After two years of decline in the number of individuals with IDD who were employed, as of June 2022 there were 660 more individuals employed than the prior year, with 61 receiving waiver-funded services. This represented a significant improvement. Despite this increase and DBHDS's reduced numerical targets, however, the Commonwealth did not achieve the measures associated with Indicator 14.8. And to meet the employment benchmark for Fiscal Year 2023, 588 more individuals still need to be employed, with 172 of these participating in waiver-funded Individual Supported Employment.

With more individuals employed, Virginia increased the related percentage from 19% to 21%. However, this still fell short of the 25% required by Indicator 14.9. This contrasts with pre-pandemic data that showed the Commonwealth achieving 24% in 2019.

Participation in Community Engagement services declined, though, by 631 individuals (from 2,650 to 2,039) between June 30, 2019 and June 30, 2022. In general, the total number of individuals participating in day activity programs is much larger than in employment services. For example, the decrease of 631 individuals participating in integrated day activities programs is almost as large as the total number of 764 individuals participating in waiver-funded integrated employment services. This decreased participation in Community Engagement services is contrary to Virginia's commitment to an annual 3.5% increase in the number of individuals authorized to receive this service, as stated in Indicator 14.10. The impact of the pandemic likely contributed to insufficient provider capacity, which appears to be the root cause of this decrease. The limited availability of this integrated service model across all Regions suggests that funding rates were inadequate. (The impact of the Commonwealth's 43%–59% increases to the funding rates for Community Engagement services in July 2022 will be studied during the Twenty-third Review Period.)

Regarding Indicator 14.1, DBHDS confirmed that all new case managers who began employment since the previous review had completed the required online training. The Department also verified that 683 case managers working in CSBs' developmental disability services completed the necessary online employment and community engagement training. The consultants confirmed that the training continued to include the required information. Virginia therefore again met the measurable outcome of this Indicator.

For Indicators 14.2–14.7, the review found improvements in DBHDS's Service Coordinator Quality Review (SCQR) process, where the number of questions asked to gather information regarding employment and community engagement discussions increased from seven to 18. The Department's Community Quality Improvement staff had determined that additional, more specific questions were needed to gather sufficient information to resolve validity concerns identified in the Nineteenth Period study.

The data from ISP meetings that DBHDS reported for Indicators 14.2 and 14.5 were not sufficient to show that these two Indicators were achieved. The Department stated that its data sets were not based, as required, on all (i.e. 100% of eligible individuals) who receive waiver services having a discussion about either employment or community engagement. Instead, DBHDS reported data related to employment discussions for only 78% of the eligible individuals (aged 18–64), and for community engagement only 80%. The Department explained that the ISPs for the remaining individuals were not completed at the time the data was reported.

For Indicator 14.3, the data that the Department reported for individuals aged 18–64 showed that only 26% of the ISPs, compared with the required 50%, showed evidence of an employment or employment-related goal. For this same age group, only 31% of the ISPs, compared with the required 86%, showed evidence of a discussion of employment, such as the aspects that individuals were working on at school to support future employment, and how waiver services can support readiness for work.

Regarding Indicator 14.4, DBHDS reported that only 72% of individuals (rather than the 86% required), whose employment services were authorized in the reporting period, had been connected with a provider and had started services within 60 days.

For Indicator 14.6, CSBs reported that community engagement goals for those whose ISP meetings were conducted between June 2021 and June 2022 were set for only 50% of individuals. This does not meet the requirement of 86%.

DBHDS utilized the SCQR process to provide data for compliance reporting related to the Department's progress toward achieving these six Indicators. The Department also provided a *Process Document* that purported to explain how any reliability and validity threats identified by its data integrity assessments were addressed, resolved and verified for each data set. However, the study found major weaknesses in the process that the Commonwealth used to collect data related to these Indicators.

For example, the data gathering process relied largely on each case manager checking a box to show that a discussion of employment or community engagement had occurred. This process, though, did not include verification that the acknowledged elements of a meaningful discussion occurred between the case manager and the individual/representative and justified the box being checked. The process also did not include an inter-rater reliability check of the information when it was entered into the WaMS data system, from which the reported data was extracted.

The *Process Document* identified the Case Management Steering Committee (CMSC) as responsible for reviewing the data set, however, there was no inter-rater reliability process to validate the submitted samples. The process described also stated that the CMSC reviews, remediates and reports on case management performance, rather than describing the actions taken that verified the data sets to be reliable and valid.

Overall, the consultants found that these weaknesses inherent in the data collection process created a highly inflated number of false positives. For example, the CSBs reported that meaningful discussions were held with 98% of the individuals studied. In contrast, the consultants' review determined such discussions taking place with only 40% of these same individuals. In summary, the data process depends on CSB self-reporting, but the accuracy of the CSB reported data and records was not verifiable to justify the case managers' checked boxes. Because of these weaknesses, the study determined that the data collection process for Indicators 14.2–14.7 did not produce valid or reliable data. In addition, Virginia's *Attestations* did not include the creation of sample data sets. Therefore, the consultants could not complete the necessary spot-check verifications.

Regarding Indicators 14.8–14.9, DBHDS reported that only 764 individuals with DD waiver services were in supported employed, compared with the target of 1,211; and that only 21% of adults aged 18–64 on the DD waivers and waitlist were employed, compared with the 25% required. The table below shows that the Commonwealth reduced the total employment target

(from 1,685 to 1,211) in an effort to achieve these Indicators, but did not meet them, since Virginia is required to attain 90% of its target.

Employment Targets for the HCBS Waiver Programs FY16-24							
End of FY	**Target Total**	**Actual Total**	**ISE Target**	**ISE Actual**	**GSE Target**	**GSE Actual**	**% of Total**
2016	808	890	211	225	597	665	100%+
2017	932	826	301	305	631	521	89%
2018	1,297	972	566	422	731	550	75%
2019	1,211	1,078	661	555	550	523	89%
2020	1,486	715	936	480	550	235	48%
2021	1,685	708	1,135	469	550	239	42%
2022	1,211	764	661	530	550	234	63%
2023	1,486		936		550		
2024	1,685		1,135		550		

ISE = Individual Supported Employment; GSE = Group Supported Employment

The Commonwealth also did not achieve Indicator 14.10. This was due to significant decreases in the number of authorizations for services in the most integrated settings, compared with the 3.5% annual increase required.

Additionally for these three Indicators (14.8–14.10), the reported data were supplied by the employment providers. The *Process Document* for the related data sets acknowledged weaknesses in four process actions and defined a manual work-around for each step. The process, created in February 2022, defined two necessary data cleaning steps to ensure that only accurately completed data sets are used in the calculations. Virginia did not provide an *Attestation* to the reliability and validity of the data reported for these Indicators.

For the Provisions that the Commonwealth had previously met, this review found that Virginia had sustained its achievements. Regarding one of these Provisions, III.C.7.d., the Commonwealth again completed significant work and most of the functions related to employment data. During the year reviewed, however, the records did not document that DBHDS discussed with the Regional Quality Councils (RQCs) the reductions in the employment targets, nor that any of the RQCs had reviewed these. The RQCs fulfilled most of their functions related to reviewing other employment data, discussing employment challenges, and making recommendations for future actions. While the RQCs did not fulfill the specific requirement to review the targets that DBHDS proposed, they had done so in earlier reporting periods.

To maintain future ratings of Sustained Compliance with Provision III.C.7.d., however, the Independent Reviewer requires that DBHDS shares next year's employment targets with the RQCs for their review, and also shares the Councils' recommendations regarding employment targets with the Employment First Advisory Group.

See the consultants' full report in Appendix B.

Conclusion

Regarding the 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., Virginia has once again maintained Sustained Compliance.

Regarding Provision III.C.7.a. (that also serves to measure Provision III.C.7.b.), the Commonwealth has met the requirements of one of the ten associated Compliance Indicators, namely 14.1, but did not achieve the remaining nine: 14.2–14.10. Therefore, Virginia remains in Non-Compliance with this Provision.

7. Transportation

Background

The Agreement's sole Transportation Provision, III.C.8.a., includes eight Indicators, 16.1–16.8. The Nineteenth Period review found that DMAS had continued to meet six of these.

For example, the Commonwealth sustained its achievement of Indicators related to contractual performance standards (16.1), separation of data for IDD users from general population users (16.3), opportunities for IDD users to participate on regional Advisory Boards (16.4), quarterly sampling of user satisfaction (16.5), convening two focus groups centering on IDD users, which provided constructive feedback (16.6), and providing Medicaid recipients with information on complaint and appeal processes (16.7).

Once again, though, DMAS had continued to utilize the previously identified invalid method of determining reliable non-emergency medical transportation (NEMT) – i.e., trips without a formal complaint being filed. However, the Department had identified potential new measures that use encounter-based trip times to generate valid on-time performance data. DMAS reported that this new data collection method would be fully implemented during the Twentieth Review

Period. If this proved to be the case, and if in the future the Independent Reviewer could verify Virginia's finding that its reported data sets were reliable and valid, and that at least 86% of recipients had reliable transportation, then the Commonwealth would achieve the requirements of Indicator 16.2.

Regarding non-NEMT transportation, Virginia made progress during the Nineteenth Review Period. To achieve Indicator 16.8, DBHDS's Quality Service Reviews (QSR) contractor was required to assess and submit an annual report to the Department's Quality Improvement Committee (QIC), showing that at least 86% of those individuals reviewed reported having reliable transportation. For the first half of Fiscal Year 2021, the vendor had indicated that 90% of those interviewed who received waiver agency-provided transportation reported having no problems. If this positive rate continued, if the information was included in the QSR annual report to the QIC, and if the Independent Reviewer could verify the Commonwealth's finding that its reported data were reliable and valid, Virginia would achieve the requirements of this Indicator.

The Nineteenth Period study showed, however, that several of these criteria were not met.

The Commonwealth met six of Provision III.C.8.a.'s eight associated Indicators, namely 16.1 and 16.3–16.7, but did not achieve Indicators 16.2 and 16.8. Virginia therefore remained in Non-Compliance with this Provision.

Twenty-first Period Study

For the Twenty-First Period study, the same consultant was retained to determine whether the Commonwealth maintained its achievement of six of the eight Indicators that it had achieved previously for Transportation Provision III.C.8.a. (namely, 16.1 and 16.3–16.7). The review also examined whether Virginia met Indicator 16.2 for the first time, and if DBHDS had fulfilled the requirements of Indicator 16.8.

Based on the review of applicable documents and interviews with DMAS and DBHDS staff, the consultant verified that the Commonwealth sustained achievement of all previously met Indicators. For example, DMAS continued to include performance standards and timeliness requirements in its transportation contracts, and fined its provider for failure to meet these standards (16.1). The Department updated its contract with Modivcare, which continued to separate IDD users in its data analysis and quality improvement processes (16.3), ensured DD Waiver users had opportunities to participate on Regional Advisory Boards (16.4), and surveyed

statistically valid samples of users to assess satisfaction quarterly (16.5). This continued to show high levels of reported satisfaction. DMAS also continued to convene focus groups (16.6) and to provide Medicaid recipients with information on filing complaints or appeals (16.7).

Once again, Virginia did not meet the requirements of Indictor 16.2. However, DMAS did implement its major new system-wide initiative to electronically measure NEMT reliability. Its methodology offers significant promise, once penalties for lack of timeliness are consistently levied, and when all drivers are connected to the new technology and are held accountable. But during the fourth quarter of Fiscal Year 2022, the new system documented an on-time performance rate of 54.8%, below the Indicator requirement of 86%. Again, this performance rate should improve over time, and DMAS is to be commended for its progress to date.

Since 2020, DMAS has held five focus groups with the required participants (16.6). The three most recent groups reflected vigorous input, including suggestions to provide training to group home staff on the Modivcare app, asking Modivcare to set up an online complaint system, and to modify the advance approval time for gas reimbursement. Complaints included that drivers were responsive only 30% of the time, and late 50% of the time. Hopefully, DMAS will perceive these focus groups as a useful source of data points, allowing the Department to identify and pursue additional system-wide quality improvement initiatives, especially regarding timely and reliable transportation. As previous Reports to the Court have noted, this has been a long-standing complaint of users.

The recent round of completed QSRs included an assessment of whether waiver-funded, agency-provided transportation facilitated participation in community activities and Medicaid services. This assessment involved questions related to receipt of Medicaid services (i.e. annual physical and dental exams), encouragement to participate in community activities, and overall satisfaction. Data were provided to the Quality Improvement Committee in its annual and quarterly reports. The level of reported satisfaction of those reviewed by the QSR has been 90% or higher for each of the last three rounds of QSRs, surpassing the 86% requirement. With these findings confirmed, the Commonwealth met the requirements of Indicator 16.8 for the first time.

The consultant's review of the *Process Document* and *Attestation* for the QSR data set related to user reports of reliable transportation showed the process steps were detailed and clearly stated, and that the reported data were reliable and valid. The reported 90% or greater satisfaction rates are consistent with the rates reported by the Individual Services Review (ISR) studies over many previous Review Periods, and also substantively exceeds the 86% Indicator metric.

See the consultant's full report in Appendix C.

Conclusion

Regarding Provision III.C.8.a.'s eight Compliance Indicators, Virginia has met the requirements of seven of them, namely 16.1 and 16.3–16.8. The Commonwealth did not achieve the remaining Indicator 16.2. Therefore, Virginia remains in Non-Compliance with this Provision.

8. Regional Support Teams

Background

Last year's Nineteenth Review Period study found that some CSBs had again failed to submit non-emergency referrals required by Regional Support Teams' (RST) protocol and timeline standards. Late referrals, or no referrals at all, had been a long-standing performance problem, effectively nullifying the core purpose of RSTs: to identify and resolve obstacles to providing small integrated living settings for people with IDD.

The review concluded that if DBHDS was to achieve the required 86% rate of submission of timely referrals to its RSTs, the department would need to take more effective actions to ensure that CSBs' case managers submitted timely referrals, and that private agencies provided timely notice to case managers of the possibility of a non-emergency change to an individual's residential setting.

The 2021 study found that DBHDS provided technical assistance, tracked data, conducted quarterly assurance reviews, completed data analysis, issued Corrective Action Plans (CAPs), 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. DBHDS had worked toward improving the integrity of RST data; however, the department's Office of Data Quality and Visualization (DQV) had not completed an assessment of the RST data source that found reliable and valid data for compliance reporting.

Overall, the Commonwealth had once again sustained Compliance with the requirements for Provisions III.E.1.–3. For Provision III.D.6., Virginia had met Compliance Indicators 20.1, 20.3, 20.4*, 20.5, 20.6, 20.8*, 20.9, 20.10*, 20.11 and 20.13*; but had not achieved Indicators 20.2, 20.7 and 20.12. (Ratings of "met*" were for illustrative purposes only, since DBHDS had not yet

verified that its reported data were reliable and valid.) Therefore, the Commonwealth remained in Non-Compliance with this Provision.

Twenty-First Period Study

To complete the Twenty-first Period study, the Independent Reviewer again retained the same consultant who had conducted all the previous reviews of the status of Virginia's achievement of the four RST Provisions and their associated Indicators.

For the three Indicators that were not met in 2021, namely 20.2, 20.7 and 20.12, DBHDS again did not meet these requirements, although evidence showed the Department made efforts throughout the past year.

DBHDS reported that the quarterly RST timeliness rates over the past fiscal year (FY 2022) ranged from 48%–68%, but still did not achieve the benchmark of 86%. This was despite the Department taking some successful steps, as described in Curative Action #4, to reduce the number of late referrals by the decision makers (i.e. the individual or the Authorized Representative). However, since the overall rate of timely referrals remained significantly below the 86% required by the Indicator, DBHDS was not able to achieve Indicator 20.2.

The Department tracked individual CSB failures to achieve Indicator 20.7's 86% RST benchmark. In response to these failures, DBHDS provided technical assistance to individual CSBs, issued CAPs, and maintained a Watch List. However, where CAPs had not resulted in sufficient improvement, the Department had not yet implemented sanctions to penalize the CSBs for long standing patterns of substandard performance. Therefore, DBHDS again did not meet the requirements of this Indicator.

The Department drafted relevant procedures needed to incorporate RST referrals into the Waiver Management Information System (WaMS) data system. This transition was underway and scheduled to be fully rolled out in December 2022. For this latest Review Period, though, DBHDS did not fulfill the requirements for Indicator 20.12.

For the four Indicators (20.4, 20.8, 20.10 and 20.13) that the Department "met" in 2021 by utilizing data that had not yet been verified as reliable and valid, DBHDS continued to fulfill the functional requirements of three of these (20.8, 20.10. and 20.13), but again did not complete the required *Process Documents* and associated *Attestations*. The Commonwealth expects to produce these required data integrity documents after the full system rollout in the Twenty-third Review

Period. For this current Review Period, however, by using data that has not yet been verified as reliable and valid, these three Indicators are again rated as "met," but this is for illustrative purposes only.

For the remaining Indicator (20.4), the Department reported Fiscal Year 2022 rates for non-emergency RST referrals of 82%, which fell below its Fiscal Year 2021 timeliness rate of 88% and below this Indicator's 86% benchmark. Therefore, DBHDS was not able to sustain achievement of this Indicator.

For Provisions III.E.1.–3., staff interviews confirmed, and documentation reviewed indicated that the Department maintained CRC staffing levels, roles and functional responsibilities that had resulted in prior determinations that DBHDS had fulfilled the requirements for these three Provisions.

The Department also established a cross-regional RST team, which began reviewing all late referrals for full RST review. As an operational step toward completing the relevant components of Curative Action #4, the cross-regional team was successful in reducing the number of cases where an individual chose to move to a less integrated setting before the RST review.

See Appendix D for the consultant's full report, including Table 2, which recaps the status of the RST Curative Action.

Conclusion

Regarding Provision III.D.6.'s 13 Compliance Indicators, Virginia has met* the requirements of nine of them, namely 20.1, 20.3, 20.5, 20.6, 20.8*, 20.9, 20.10*, 20.11 and 20.13.* The Commonwealth did not achieve the remaining four: 20.2, 20.4, 20.7 and 20.12. Therefore, Virginia remains in Non-Compliance with this Provision.

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

**Note*: Since DBHDS has not yet provided a fully completed *Process Document* and/or a signed *Attestation* regarding its data reliability and validation, ratings of "met*" are not yet final and cannot be used for Compliance determinations, but rather are for illustrative purposes only.

9. Mortality Review

Background

The Nineteenth Period mortality review examined the Commonwealth's status fulfilling the requirements of Provision V.C.5. and its associated Indicators, including the implementation of quality improvement initiatives intended to reduce the rate of deaths of individuals with IDD.

The study found that the Mortality Review Committee (MRC) had taken significant steps toward fulfilling the requirements of Indicators 33.1–33.21. With the assistance of DBHDS's Office of Licensing's (OL's) Specialized Investigations Unit (SIU) and new regulations that allowed the Department access to medical records from several sources, the MRC reduced the number of deaths that it categorized as due to unknown causes, and increased the number that it categorized as potentially preventable deaths from 17 in Fiscal Year 2020 to 39 in Fiscal Year 2021.

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 implemented a more thorough information gathering process that resulted in reducing the number of unreported deaths.

However, Virginia did not keep up with its past mortality review completion rate within the 90-days of death period, as required by Indicators 33.13 and 33.15.

Again, DBHDS had not yet determined that the data sources used by the MRC provided reliable and valid data for compliance reporting.

The Nineteenth Period study concluded that the Commonwealth had met 19 Indicators of Provision V.C.5.: 33.1–33.8, 33.9*–33.12, 33.14 and 33.16–33.21, but had not achieved two Indicators, 33.13 and 33.15. (The rating of "met*" for Indicator 33.9 was for illustrative purposes only, since the Department had not yet verified that its reported data were reliable and valid.) Virginia therefore remained in Non-Compliance with this Provision.

Twenty-first Period Study

For the Twenty-first Period's review, the Independent Reviewer retained the same consultant to assess the status of the Commonwealth's planning, development and implementation of the MRC membership, process, documentation, reports, and Quality Improvement Initiatives (QIIs), in order to evaluate the achievement of the 21 Indicators associated with Provision V.C.5. The review encompassed a full year (August 2021 through July 2022), during which the MRC continued to implement changes and make progress.

This latest study included a review of extensive MRC and related documentation, as well as interviews with MRC and other DBHDS staff. The consultant examined the actual documents that the MRC reviewed for each death as well as the primary source documents, which were summarized for the MRC reviews. Spot checks were also conducted to verify the reliability of the data reported by the MRC.

The frequency of MRC meetings, expanded membership, additional information and a robust multidisciplinary approach resulted in improved quality, consistency and completeness of mortality reviews. The MRC continued to utilize its ability to access death certificates and medical records from a variety of settings. It maintained an inventory of received documents that allows for an efficient document review process in preparation for its meetings. In addition, by using a standardized format, the MRC ensured the availability of essential information for its reviews. The SIU continued to provide information to the MRC which allowed for more accurate categorization of deaths as expected/unexpected and potentially preventable, as well as determinations of the causes of deaths. As a result, the MRC effectively categorized a reduced number of cases as having an unknown cause of death, and increased the clarity of its conclusions regarding whether maltreatment was a concern.

From April through August 2022, five of the six months of the Twenty-first Review Period, the MRC improved the rate at which it reviewed unexpected deaths within 90 days to 76.5% (75 of 98). Nonetheless, Virginia once again did not achieve the 86% measure required by Indicators 33.13 and 33.15.

Regarding Indicator 33.16, for the period January 1–July 31, 2022, the consultant verified that, following the Parties' agreement to Curative Action #7, the MRC utilized the specified categories of deficits. The study also verified that all deaths determined by the MRC as potentially preventable were properly categorized, and that the MRC reviews identified one or more prevention levels, as required. For the period reviewed, the number of potentially

preventable deaths declined. However, the number of these deaths and the time period reviewed were not sufficient to determine if this decline resulted from improvements in caregivers calling 911 in a timely manner, or from other associated trainings provided by DBHDS's Office of Integrated Health. The Commonwealth continued to achieve this Indicator.

The review verified that the MRC continued to meet the requirements of the 19 Compliance Indicators that it had achieved in 2021. For example, the MRC Charter included all the elements required, its membership exceeded the requirements, training of members occurred, and implementation of the MRC recommendations was tracked through to closure. This study also confirmed that OL maintained the system, structure and operations of its SIU and met the timelines required by the applicable Indicator.

In addition, the MRC met the Indicator requiring publication of its annual report (33.17) within six months of the end of the year, and the consultant verified that this report included all of the elements required. The MRC documented its recommendations for the needed quality improvement initiatives (33.18), recommendations to the QIC and the Commissioner (33.19), and DBHDS staff reported data to enable the MRC to track implementation (33.20). The consultant's report outlines several related recommendations beyond the minimum requirements of these Indicators.

DBHDS achieved the requirements for Indicator 36.1 concerning the mortality review process. *Attestations* for Indicators 33.9 and 33.13 were completed and included the data set reviewed, the review for completeness and representation of the data intended to be collected, and the MRC process and steps taken by the Data Analyst to ensure the reliability and validity of content. The spot checks conducted by the consultant verified the accuracy and reliability of the data that Virginia reported for this study.

In November 2021, the Parties agreed to Curative Action #7 for Indicator 33.16, which states planned actions to facilitate accomplishment of Provision V.C.5. In January 2022, the MRC incorporated the definitions specified in the Curative Action into its review process. It also began to apply these criteria to appropriately determine which deaths are potentially preventable and to specify the primary, secondary and tertiary prevention strategies. With the availability of additional documents, including those provided by the SIU, the MRC utilized more complete and accurate information to categorize deaths as potentially preventable.

See Appendix E for the consultant's full report, including attachments of specific facts that were analyzed and verified.

Conclusion

Regarding Provision V.C.5., the Commonwealth has again met 19 of its 21 Indicators, namely 33.1–33.12, 33.14, and 33.16–33.21. Virginia did not achieve the remaining two: 33.13 and 33.15. Therefore, the Commonwealth remains in Non-Compliance with this Provision.

10. Office of Licensing and Office of Human Rights

Background

Beginning April 2021, DBHDS's Offices of Licensing (OL) and Human Rights (OHR) gradually reinstituted face-to-face, onsite activities that had been suspended during the pandemic. OL and OHR continued to operate competently, both Offices sustained, refined and strengthened the functioning of their oversight systems, and the Department demonstrated that it had fulfilled the Indicators requiring onsite assessments.

OHR had established a positive new initiative to identify incidents that should have been reported via DBHDS's real-time, web-based incident reporting system, Computerized Human Rights Information System (CHRIS). This initiative involves cross-tabulating incidents reported through CHRIS with those reported through Virginia's Adult Protective Services and Child Protective Services (APS/CPS) agencies. This process is similar to the cross-tabulation of the CHRIS incident reports with Medicaid's medical claims data for emergency room visits and unplanned hospitalizations. Both identify potentially reportable incidents that are reviewed by DBHDS with the relevant service providers.

If confirmed that the provider should have reported the incident through CHRIS, DBHDS requires the provider to implement and complete a Corrective Action Plan (CAP). These cross-checking processes increase the accountability of the Commonwealth's service providers, as well as improving the accuracy of the data regarding timely reporting. The Nineteenth Period study confirmed that OL had followed up appropriately with providers that were required to complete CAPs, and if the unreported incidents involved health and safety violations, the Office ensured that CAPs had been implemented within the applicable timeframes.

DBHDS also stated it had maintained timely incident reporting at a rate above the associated Indicator-required level of 86%. The OL licensing processes that include its Adequacy of Services (AOS) assessments continued to address seven of the eight domains listed in Provision V.D.3. For the eighth domain, DBHDS gathered data from another source, its Crisis Services system.

Overall, the Commonwealth met seven of Provision V.C.6.'s eight Compliance Indicators: 34.1–34.4* and 34.6*–34.8*, but did not achieve the remaining Indicator 34.5. Therefore, Virginia remained in Non-Compliance with this Provision. Regarding Provision V.G.3., the Commonwealth continued to meet its four associated Compliance Indicators: 48.1–48.4,* but remained in Non-Compliance due to Virginia not verifying that its reported data for Indicator 48.4 were reliable and valid. The Commonwealth also maintained Sustained Compliance with Provisions V.C.2., V.C.3., V.G.1. and V.G.2.

Twenty-first Period Study

For this Period, the same consultant was retained to determine whether Virginia had maintained Sustained Compliance with the Provisions already sustained for a number of years. The study also reviewed Provision V.C.6. to examine if the Commonwealth had met Indicator 34.5 for the first time, and if DBHDS had established the reliability and validity of its reported data sets for Provision V.G.3.

Virginia maintained Sustained Compliance with Provisions V.C.2., V.C.3., V.G.1. and V.G.2. DBHDS sustained and periodically improved the data sets documenting timely reporting, as well as its process to investigate incidents and identify remediation steps as needed. OL continued to conduct regular, more frequent, and unannounced licensing inspections. Since initially achieving Compliance with these Provisions, OL and OHR monitored and improved their processes consistent with the requirements.

This Period's study verified that, as required by Provisions V.C.2. and V.C.3., OL and OHR continued to identify and track late incident reporting by licensed provider agencies, including CSBs. DBHDS's tracking protocols included review of incident reports submitted through CHRIS, as well as through inspections, investigations, and information from external agencies. As required by Provision V.C.6.'s Indicators 34.1 and 34.2, the Department also maintained its processes to identify unreported incidents by cross-tabbing its CHRIS records with reports from Adult and Children Protective Services, DMAS Medicaid claims for emergency room visits and hospitalizations, and the Commonwealth's Department of Health records of death certificates. As

required, the Medicaid claims data included information about individuals receiving services through Virginia's three DD waivers and three waiver-funded residential services. OL made regulatory changes to clarify that all emergency hospitalizations require incident reports.

DBHDS stated that 97% of incidents were reported within its expected timeline. This rate exceeds Indicator 34.4's required 86% benchmark. The 97% rate was determined after the Department completed a written manual work-around process that filtered out duplicate reports. Such reports occur when non-residential provider agencies notify the Department of the same incident, but after the required within 24-hour timeline.

DBHDS provided a *Process Document* and an *Attestation* for the reported data related to Indicator 34.4.'s timely reporting requirements. However, the most recent Key Performance Area (KPA) Performance Measure Indicator (PMI) identified several unresolved data integrity issues, which were not listed in the *Process Document*. Even though this Indicator was conditionally met, the reliability and validity of the Commonwealth's reported data could not be verified once again.

Over the last two years, OL and OHR have systematically improved their tracking of agencies for late incident reporting and CAPs. Provider CAPs reviewed also indicated an elevated level of attention to tracking the timely reporting of incidents. The Commonwealth conditionally achieved Indicator 34.5 for the first time, because the reliability and validity of DBHDS's reported data could not be verified.

OL continued to review, approve and track implementation of CAPs for agencies cited for late reporting, as required by Indicator 34.6. Since the previous study, OL issued revised instructions on the handling of follow-up assessments of implementation. As required by Indicator 34.7, OL also implemented and tracked further actions toward providers who failed to correct violations after the initial CAP. For these providers, such actions resulted in consent agreements, voluntary closures, or provisional licensing. Also since the 2021 review, DMAS raised the stakes for providers who fail to implement CAPs, as that Department will no longer pay claims past 60 days to providers with provisional licenses.

For Indicator 34.8, DBHDS had policies in place that specify requirements for Training Centers to report serious incidents, as well as to implement and monitor corrective actions. OHR reviewed incidents monthly and annually to determine if identified causes were addressed.

DBHDS provided a *Process Document* for this Indicator. Since the OHR reviews are triggered by a CHRIS report, this was appropriate, although no *Attestation* was supplied that CHRIS provided reliable and valid data.

The Department's AOS checklist items continued to tie its specific corresponding regulations to seven of the eight domains. The ongoing development and use of the AOS checklist in DBHDS's assessments resulted in the Commonwealth again meeting the requirements of Indicator 48.1. Since implementing the checklist, OL has refined, expanded and improved its use. Previously, for the eighth domain (i.e., Stability), DBHDS had solely utilized non-OL data from its Crisis Services system. OL now provides Stability information from its inspections related to face-to-face contacts by case managers.

Although described as a checklist, the AOS process became more central to OL's system of monitoring and oversight, not only of IDD services, but also of Behavioral Health and Substance Abuse services. In addition, the accuracy of the data collected under the AOS framework was enhanced via a look-behind process where the Office's Regional Managers review all Licensing inspection reports. Importantly, this overall AOS process has increased focus on the adequacy of services that reflect the theme of the eight AOS domains.

OL again informed and supplied subsequent updates of the AOS assessment process to providers. The Office also continued to submit semi-annual reports to the Case Management Steering Committee (CMSC) and relevant KPA workgroups. Additionally, OL produced a trend report for the QIC, and, as a result, quality improvement initiatives were generated.

DBHDS provided a *Process Document* for Indicator 48.4. Although this did not specifically reference how past data integrity problems were resolved, documents from OL and the Office of Data Quality and Visualization (DQV) separately identified the modifications and updates implemented to address and resolve these data integrity concerns. This Period's study included a look-behind, spot-check review that verified the reliability of the data that DBHDS reported, resulting in a determination by the Independent Reviewer that this Indicator's requirements were fully met for the first time.

See the consultant's full report in Appendix F.

Conclusion

Regarding Provisions V.C.2., V.C.3., V.G.1. and V.G.2., Virginia maintained Sustained Compliance.

Regarding Provision V.C.6.'s eight Compliance Indicators, the Commonwealth has met* the requirements of all of them, namely 34.1–34.4*, 34.5* and 34.6–34.8.* Therefore, Virginia remains in Non-Compliance with this Provision.

Regarding Provision V.G.3., the Commonwealth has met this Provision's four Compliance Indicators 48.1–48.4. Virginia has therefore achieved Compliance with this Provision for the first time.

**Note*: Since DBHDS has not yet provided a fully completed *Process Document* and/or a signed *Attestation* regarding its data reliability and validation, ratings of "met*" are not yet final and cannot be used for Compliance determinations, but rather are for illustrative purposes only.

11. 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 two RQC-related Provisions, V.D.5. and V.D.5.b., specify that DBHDS develops and implements these RQCs, whose membership comprises service system stakeholders and is staffed by the Department. DBHDS's Quality Improvement Committee (QIC) directs the Councils' operations. The RQCs' responsibilities are to assess relevant data, identify trends, and recommend responsive actions to improve services in their respective Regions.

The Nineteenth Period's review studied the progress DBHDS had made in each of the five Regions. All had convened regular quarterly meetings and served as subcommittees to the QIC. The RQC minutes showed improvement 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 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, their work was compromised by a lack of baselines and measurable outcomes.

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

Of Provision V.D.5.'s five Compliance Indicators, the Nineteenth Period study concluded that Virginia had met three of them (39.1–39.3), but did not achieve the remaining two, 39.4–39.5. Regarding Provision V.D.5.b.'s seven Indicators, the Commonwealth met five (40.1, 40.2*****, 40.3, 40.4 and 40.6), but did not achieve two, 40.5 and 40.7. Virginia therefore remained in Non-Compliance with both Provisions.

Twenty-first Period Study

For the latest study, the Independent Reviewer retained the same consultant to examine the Commonwealth's progress regarding RQCs and the achievement of its two Provisions, V.D.5. and V.D.5.b., together with their total of 12 Compliance Indicators.

During this Period, Virginia sustained its achievement of those Indicators previously met. Additionally, the Commonwealth made significant progress toward achieving the Indicators that were unmet in the prior review.

The minutes from each RQC meeting consistently showed that DBHDS provided the Councils with comparisons of current data with that from previous quarters. This allowed RQC members to easily visualize trends over time and, as a result, to formulate questions and requests for additional information.

On another positive note, the Councils used QI initiative toolkits to develop their proposed initiatives. The guidance from these toolkits addressed the key components of measurability that had been lacking previously. Therefore, Virginia met* Indicator 39.4 for the first time. This determination is conditional, however, because some of the data DBHDS presented to the RQCs was not found to be reliable and valid.

All five RQCs documented at least one QI recommendation. The Councils also reported to the QIC on their monitoring of statewide QI initiatives and their subsequent analyses of these.

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

Conclusion

The Twenty-first Period study concluded that Virginia has met* all of the 12 Compliance Indicators for Provisions V.D.5. (39.1–39.5) and V.D.5.b. (40.1–40.7), compared with having met eight of these Indicators during the Nineteenth Period review.

Regarding Provision V.D.5.'s five Compliance Indicators, the Commonwealth has met* all of them, namely 39.1–39.3, 39.4* and 39.5.* Therefore, Virginia remains in Non-Compliance with this Provision.

Regarding Provision V.D.5.b.'s seven Compliance Indicators, the Commonwealth has met* all of them, namely 40.1, 40.2,* 40.3, 40.4, 40.5,* 40.6 and 40.7. Therefore, Virginia remains in Non-Compliance with this Provision.

**Note*: Since DBHDS has not yet provided a fully completed *Process Document* and/or a signed *Attestation* regarding its data reliability and validation, ratings of "met*" are not yet final and cannot be used for Compliance determinations, but rather are for illustrative purposes only.

12. Public Reporting

Background

The purpose of the Compliance Indicators associated with Public Reporting's two Provisions, V.D.6. and IX.C., are for the Commonwealth to provide the public with current information about the availability and quality of supports and services for individuals with IDD and their authorized representatives. This documentation includes recent demographics about individuals served, as well as the capacity of services either provided or available to them. In addition, Virginia is to inform the Independent Reviewer of any gaps in such services, as well as to provide related records.

The Commonwealth is expected to publish an *Annual Quality Management Report and Evaluation* that includes reported data regarding performance measures, Quality Improvement (QI) initiatives

and systemic challenges. Additional reports, including those related to licensing inspections and investigations, Quality Services Reviews (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 Nineteenth Review Period in 2021, Virginia did not meet any of the nine Indicators for these two Provisions. This was due primarily to DBHDS's failure to post or update the required records on the Library website, including annual updates to the specified documents.

Based on that Period's study, the Independent Reviewer determined that the Commonwealth had not achieved either Provision V.D.6 or Provision IX.C.

Twenty-First 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.

During this Period, Virginia made improvements toward achieving the five Indicators (41.1–41.5) associated with Provision V.D.6. DBHDS posted its *Provider Data Summary Semi-Annual Report State Fiscal Year 2021.* As required for Indicators 41.1–41.3, this included annual performance and trend data, demographics, strategies to address identified gaps in services and recommendations for improvement, as well as the implementation of any such strategies.

The Department also posted its latest *Developmental Disabilities Quality Management Plan State Fiscal Year 2021*, which included information for all the topics defined in Indicator 41.4. DBHDS staff reported plans to implement changes to publication timeliness so that more current information would be available in the future.

However, DBHDS did not determine that its data sets used to support compliance findings associated with these four Indicators were reliable and valid, and so the Commonwealth only conditionally met these Indicator requirements.

For Indicator 41.5, the Department did not submit the required additional or updated documentation on the Library site, although some were posted on its website. Also, DBHDS did not indicate whether its *DOJ Settlement Agreement Library Protocol* remained current.

In general regarding Provision IX.C.'s four Indicators (54.1–54.4), the required documentation was either not available on the Library site or a current version was not made available for review. For Indicator 54.1, DBHDS did not provide any additional protocols or updates for review of its *Settlement Agreement Library Record Index* and the *DOJ Settlement Agreement Library Protocol*, both of which were over two years old.

This Period's study could not verify that the June 2020 version of the *Settlement Agreement Library Record Index* fulfilled the requirements of Indicator 54.2. In addition, as specified in Indicators 54.3 and 54.4, the Department did not post any related documents or updates for review, and did not maintain its Library in accordance with the applicable *Library of Virginia Records Retention and Disposition Schedules*.

As a result, the Commonwealth did not meet the requirements of these four Indicators.

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

Conclusion

Regarding Provision V.D.6.'s five Compliance Indicators, the Commonwealth has met* four of them, namely 41.1*–41.4,* but did not achieve the remaining Indicator 41.5. 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, namely 54.1–54.4. Therefore, Virginia remains in Non-Compliance with this Provision.

**Note*: Since DBHDS has not yet provided a fully completed *Process Document* and/or a signed *Attestation* regarding its data reliability and validation, ratings of "met*" are not yet final and cannot be used for Compliance determinations, but rather are for illustrative purposes only.

III. CONCLUSION

During the Twenty-First 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.

Overall, the Commonwealth maintained Sustained Compliance with 22 Provisions. Of the 180 Compliance Indicators studied, Virginia fully or conditionally met 127, with the Commonwealth's data showing 24 Indicators were achieved for the first time. However, for 16 of these newly met Indicators, the data reported were not verified as reliable and valid.

Throughout both the Twentieth and Twenty-first Review Periods, while the pandemic lingered and some of its impacts persisted, Virginia continued to implement and strengthen its monitoring processes. Its Offices of Licensing and Human Rights largely achieved the Agreement's requirements. DBHDS's Quality Services Review (QSR) process was improved and its Regional Quality Councils and Quality Improvement Committee increasingly fulfilled their respective functions. The Commonwealth also undertook a number of effective steps to improve data integrity.

Although strengthened, Virginia's QSR and its quarterly case management onsite assessments were not properly implemented. They did not sufficiently identify the most significant obstacles to the delivery of quality services. In addition, many of the Commonwealth's monitoring systems, while improved, still did not consistently report reliable and valid data. Together, the inadequacies of the monitoring systems and data reporting continued to undermine Virginia's ability to target and implement needed quality improvement initiatives that will ensure appropriately delivered and good quality services for individuals with IDD.

For the Twenty-second Review Period, the Independent Reviewer plans to study the status of the Commonwealth's progress toward fulfilling the requirements of those Provisions and their associated Indicators not reviewed during the Twenty-first Period. These include:

- Quality and Risk Management (Provisions V.B. and V.C.1.);
- Case Management;
- Crisis Services;
- Behavioral Supports Programming;

- Individual and Family Supports, Guidelines for Families, and Family-to-Family and Peer programs;
- Community Living Options;
- Mortality Reviews (Provision V.C.5.'s Indicators 33.13 and 33.15);
- Independent Living Options; and
- Waiver Slots

Throughout this Twenty-first 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. The willingness of both Parties to openly and regularly discuss implementation issues and to negotiate targeted Curative Actions to facilitate achievement of specific Indicators has been impressive and productive. The involvement and contributions of advocates and other stakeholders have helped the Commonwealth to formulate policies and processes and make measurable progress toward fulfilling its promises to all 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 15 actions listed below, and provide a report that addresses these recommendations and their status of implementation by March 31, 2023. 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-third Review Period (April 1, 2023 – September 30, 2023).

Quality and Risk Management

1. DBHDS should standardize the format of its *Process Documents* to ensure that each includes at least the following: the previously identified threats to data reliability and validity, the

actions taken that resolved them, and the methods that verified the currently reported data set. Relevant document dates and titles should also be included.

2. DBHDS should create a protocol to determine how revisions to *Process Documents* will be managed to ensure that each accompanying *Attestation* is current with and based on the content of the most recent *Process Document*.

Provider Training

3. The Commonwealth should determine how it fulfills the requirements, documents, and reports reliable and valid data to verify that 95% of Direct Support Professionals (DSPs) and their supervisors receive competency-based training, and that DSPs who have not yet completed such training are accompanied and overseen by other qualified staff.

4. DBHDS and DMAS should implement their plans for a coordinated scheduling system to assure providers that reviews conducted by the two Departments, as well as the QSR vendor will not occur close together throughout the year. These plans should include a repository for submission of required reference documents, so that providers only need to scan and submit each of them once.

Quality Service Reviews

5. DBHDS should ensure that the QSR vendor develops and implements additional training, tool questions and protocols to identify and address gaps not already identified in Individual Supports Plans (ISPs). These should include significant emphasis on reviewing clinical indicators and needs regarding attainment or maintenance of functional skills through direct or consultative occupational, physical, or speech and language therapy, and whether those needs have been addressed.

6. The QSR vendor should submit more specific and actionable recommendations to the Quality Improvement Committee (QIC) that provide greater insight into the commonalities and possible root causes underlying the identified opportunities for improvement.

Integrated Day Activities and Supported Employment

7. The Commonwealth should review and determine the root causes of the continuing decline in the number of individuals participating in Community Engagement programs, and take necessary actions to address and resolve this.

8. Virginia should increase training and supervision of CSB case managers to ensure that Individual Supports Plan goals are written in measurable terms so that progress can be reliably determined, attained within a year, and promotes participation by individuals with IDD in their communities.

9. DBHDS and the CSBs should prioritize training, supervision and direction provided to case managers regarding engaging in meaningful discussions and setting specific, measurable, achievable, relevant and time-based (SMART) goals.

Transportation

10. DMAS should maintain records that document its analysis to determine variables associated with on-time performance, address root causes of delays, identify and take corrective actions with drivers with above-average late rates, as well as any additional initiatives to improve on-time performance.

Regional Support Teams

11. DBHDS should require providers to give sufficient advanced notice to individuals, authorized representatives, CSBs and the Department itself of planned group home closures to allow for adequate planning, choice and referral to the relevant Regional Support Team.

Mortality Review

12. The Mortality Review Committee should include a status report in its *Annual Mortality Report* regarding prior years' recommendations and quality improvement initiatives designed to reduce mortality rates to the greatest extent practicable.

Office of Licensing and Office of Human Rights

13. DBHDS should collect and track its Adequacy of Supports (AOS) annual inspections data separately from its AOS investigations data to ensure that year-over-year trends are not distorted by a higher percentage of negative findings that are typically identified in its investigations.

Regional Quality Councils

14. Regional Quality Councils should document, to the extent practicable, their criteria for ensuring that quality improvement goals and objectives are written in terms that are measurable and time-based.

Public Reporting

15. DBHDS should review and rectify, as needed, the level of resources assigned so that it is able to adhere fully to the expectations described in the *DOJ Settlement Agreement Library Protocol*, dated June 30, 2020, for maintaining and updating its Library site with all needed documentation. This will ensure that the Commonwealth can make such records available to the Independent Reviewer and his consultants on request. .

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 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 21st Period are not in bold. Ratings for the 21st 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.-ix.	The Commonwealth shall create a minimum of 805 waiver slots to enable individuals in the target population in the Training Centers to transition to the community according to the… schedule (in i-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.*

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) according to the …schedule (in i.-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.* *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) according to the … schedule (in i-x).	Sustained Compliance	*See Comment re: III.C.1.b.i-ix.*
III.C.2.a.-i.	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 20th Period, the Commonwealth met the requirements for three of the twelve Compliance Indicators, 1.01-1.12. The Commonwealth met Indicators 1.5, 1.8, and 1.12. It has not met 1.1–1.4, 1.6, 1.7, and 1.9–1.11, 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	*207 (100%) of the individuals reviewed in the Individual Services Review studies during the 10th, 11th, 12th, 13th, 14th, 15th, 16th, 18th., and 20th 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 ten Compliance Indicators, 2.1-2.5 and 2.16-2.20. Indicator 2.05 has ten required elements (2.06-2.15).* *Virginia met four of the Indicators 2.1, 2.4, 2.17 and 2.19, but has not met six Indicators 2.2, 2.3, 2.5 (includes 2.6 –2.15), 2.16, 2.18, and 2.20.*
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 achieves 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 achieves 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 Compliance	*The Commonwealth has met all four Compliance Indicators, 6.1-6.4. Therefore, Virginia has achieved Compliance for the first time.*
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 seventeen of the twenty-three Compliance Indicators 7.2-7.23. It met Indicators 7.2-7.7, 7.9-7.13, 7.15-7.17 and 7.21-7.23, but has not met the five Indicators 7.8, 7.14, and 7.18-7.20, 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 seven 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 all of the seven Compliance Indicators 8.1–8.5, 8.6*, and 8.7*. However, its data has not been established as reliable and valid. Met* ratings are for illustrative purposes only, therefore Virginia 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 19th and 20th 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 many 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 three of the Compliance Indicators 10.01, 10.2, 10.3, but did not achieve 10.4, and therefore remains in Non Compliance.*

Settlement Agreement Reference	Provision	Compliance Rating	Comments
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 Non Compliance	*The Commonwealth did not meet the sole indicator 11.1, and therefore remains in Non Compliance.*
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.	Compliance Non 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.	Compliance Non Compliance	*The Commonwealth met two Compliance Indicators 13.1 and 13.2, but did not achieve 13.3, and therefore has not maintained Compliance.*
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 14.1. The Commonwealth has again not met Indicators 14.2 14.3, 14.4, 14.5, 14.6, 14.7. 14.8, 14.9, 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. Its updated plan includes outcomes and bench marks for FY 21–FY 23
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 sixth 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**	RQCs did complete a quarterly review of employment data and consultation as required.
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**	RQCs did complete a quarterly review of employment data but did not document discussions with the RQCs regarding employment targets.
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 16.1, 16.3, 16.4, 16.5, 16.6, 16.7 and 16.8. The Commonwealth has not met Indicator 16.2.
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	Compliance Sustained Compliance	*The Commonwealth again met the two Compliance Indicators 17.1 and 17.2 and therefore has Sustained Compliance for the first time.*
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 seventeen*, of the twenty-three Indicators 18.1-18.23. It met Indicators 18.1*, 18.7, 18.8, 18.10–18.18, 18.19*, 18.20–18.23, but did not meet the six Indicators 18.2–18.6 and 18.9, and therefore remains in Non-Compliance.*

Settlement Agreement Reference	Provision	Compliance Rating	Comments
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 12/31/21, the Commonwealth had created new options for 1,732 individuals who are now living in their own homes. This is 1,391 more individuals than the 341 individuals who were living in their own homes as of 7/1/15. This accomplishment is 92% 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.*
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.*

Settlement Agreement Reference	Provision	Compliance Rating	Comments
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 19.1-19.3. It met Indicator 19.1, but did not meet 19.2 and 19.3, 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 20.1, 20.3, 20.5, 20.6, 20.8*, 20.9, 20.10*, 20.11 and 20.13*; but has not achieved Indicators 20.2, 20.4, 20.7 and 20.12. Therefore, Virginia remains in Non-Compliance with this Provision. See * Note below.
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 a 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.

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

Settlement Agreement Reference	Provision	Compliance Rating	Comments
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.*
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.*

Settlement Agreement Reference	Provision	Compliance Rating	Comments
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.*
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.*

Settlement Agreement Reference	Provision	Compliance Rating	Comments
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.*
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.*

Settlement Agreement Reference	Provision	Compliance Rating	Comments
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 are timely identified and engaged in preparing for the individual's transition.	COMPLIANCE*	*The Individual Services Review studies determined that PSTs and case managers assisted individuals and their Authorized Representative. Interviews and documents 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.*

Settlement Agreement Reference	Provision	Compliance Rating	Comments
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.*
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.*

Settlement Agreement Reference	Provision	Compliance Rating	Comments
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.*
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.*

Settlement Agreement Reference	Provision	Compliance Rating	Comments
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.*
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.*

Settlement Agreement Reference	Provision	Compliance Rating	Comments
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.*
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.*

Settlement Agreement Reference	Provision	Compliance Rating	Comments
IV.D.4.	The CIM shall provide monthly reports to DBHDS Central Office regarding the types of placements to which individuals have been placed.	COMPLIANCE*	*The CIM provides monthly reports and DBHDS provides the aggregated weekly and. monthly information to the Reviewer and DOJ.*
V.	**Quality and Risk Management System**	Ratings prior to the 21st Period are <u>not</u> in bold. Ratings for the 21st 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.A.	To ensure that all services for individuals receiving services under this Agreement are of good quality, meet individuals' needs, and help individuals achieve positive outcomes, including avoidance of harms, stable community living, and increased integration, independence, and self-determination in all life domains (e.g., community living, employment, education, recreation, healthcare, and relationships), and to ensure that appropriate services are available and accessible for individuals in the target population, the Commonwealth shall develop and implement a quality and risk management system that is consistent with the terms of this Section.		Provision V.A. will be in Compliance when the Commonwealth is determined to comply with all the requirements of the Provisions and associated Compliance Indicators in Section V. Quality and Risk Management System.

Settlement Agreement Reference	Provision	Compliance Rating	Comments
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 29.1-29.33. It met Indicators 29.3, 29.5, 29.6, 29.7, 29.9, 29.11, 29.12, 29.13*, 29.15*, 29.31, and 29.32, but did not meet the remaining 23: 29.1, 29.2, 29.4, 29.8, 29.10, 29.14, 29.16–29.30, and 29.33.*
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* seven of the eleven Compliance Indicators 30.1-30.11. It met Indicators 30.1–30.3, 30.5*, 30.6, 30.8, and 30.9, but did not achieve the remaining four: 30.4, 30.7, 30.10 and 30.11.*
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 32.1–32.3, 32.5, 32.6, 32.8, and 32.9. The Commonwealth has not met Indicators 32.4 and 32.7.

Settlement Agreement Reference	Provision	Compliance Rating	Comments
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 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.	Non Compliance **Non Compliance**	The Commonwealth has met Compliance Indicators 33.1, 33.2, 33.3, 33.4, 33.5, 33.6, 33.7, 33.8, 33.9, 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.
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 34.1, 34.2, 34.3, 34.4*, 34.5*, 34.6, 34.7, and 34.8*. The Commonwealth remains in Non-Compliance. *See note at the bottom of this Compliance Table.

Settlement Agreement Reference	Provision	Compliance Rating	Comments
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 35.2, , 35.3*, 35.4, 35.6 and 35.8*. The Commonwealth has not met Indicators 35.1, 35.5, and 35.7.
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 36.2*, 36.4*, 36.5, 36.6* and 36.7*. The Commonwealth has not met Compliance Indicators 36.1, 36.3, and 36.8.
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 37.1*, 37.2* 37.3, 37.4, 37.5* –37.6* 37.8–37.9, 37.10*, 37.11, 37.12*, 37.13, , 37.14*, 37.15, 37.16*, 37.17, 37.18*, 37.19, 37.20*, 37.21, 37.22*, 37.23 and 37.24*. The Commonwealth has not met Indicators 37.7.

Settlement Agreement Reference	Provision	Compliance Rating	Comments
V.D.4.	The Commonwealth shall collect and analyze data from available sources, including the risk management system described in V.C. above, those sources described in Sections V.E-G and I below (e.g. providers, case managers, Quality Service Reviews, and licensing), Quality Service Reviews, the crisis system, service and discharge plans from the Training Centers, service plans for individuals receiving waiver services, Regional Support Teams, and CIMs.	Non Compliance **Non Compliance**	The Commonwealth has not met Compliance Indicator 38.1.
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 39.1, 39.2, 39.3., 39.4*, and 39.5*. The Commonwealth remains in Non-Compliance. *See note at the bottom of this Compliance Table.
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 be directed by a DBHDS quality improvement committee.	Non Compliance **Non Compliance**	The Commonwealth has met Compliance Indicators 40.1, 40.2*, 40.3, 40.4, 40.5*, 40.6 and.40.7. The Commonwealth remains in Non-Compliance. *See note at the bottom of this Compliance Table.
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 met Compliance Indicators 41.1*, 41.2*, 41.3*, and 41.4*, but has not met Indicator 41.5, and therefore remains in Non-Compliance.

Settlement Agreement Reference	Provision	Compliance Rating	Comments
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 Indicators 42.1 42.2, and 42.5 The Commonwealth has not met Indicators 42.3 and 42.4.
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 43.1, 43.2, 43.3 and 43.4.
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 met Indicators 44.2* The Commonwealth has not met Indicators 44.1.
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	*The case management and the ISR study found Compliance with the required frequency of visits, many of which are remote due to COVID precautions. DBHDS reported data that some CSBs are below target.*

Settlement Agreement Reference	Provision	Compliance Rating	Comments
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 46.1 and 46.2, 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 **Compliance**	The Commonwealth met all four Compliance Indicators 48.1, 48.2, 48.3 and 48.4. The Commonwealth achieved Compliance for the first time.

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 49.1, 49.5, 49.6, 49.7,49.8, 49.9, 49.10, 49.11, and 49.13. The Commonwealth has not met Indicators 49.2, 49.3, 49.4, 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.	**Sustained Compliance** **Sustained Compliance**	The Commonwealth met all three Compliance Indicators 50.1, 50.2, and 50.3, and has achieved Compliance for the third 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**	Of this Provision's five Compliance Indicators, the Commonwealth met one (51.1), but has not met four (51.2–51.5).
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**	Of this Provision's seven Compliance Indicators, the Commonwealth met four (52.3–52.6), but has not met two (52.1–52.2).
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**	Of this Provision's four Compliance Indicators, the Commonwealth met two (53.1–53.2), but has not met two (53.3–53.4).
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 annual QSR process based on a statistically significant sample of individuals.

Settlement Agreement Reference	Provision	Compliance Rating	Comments
VI.	**Independent Reviewer**	**Rating** **COMPLIANCE*** Provisions achieved 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 for the 21st Period are in **bold.**	**Comment**
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 Commonwealth has not met any of this Provision's four Indicators (54.1—54.4) and therefore remains in Non-Compliance.

**Note*: Since DBHDS has not yet provided a fully completed *Process Document* and/or a signed *Attestation* regarding its data reliability and validation, ratings of "met*" are not yet final and cannot be used for Compliance determinations, but rather are for illustrative purposes only.

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

VI. APPENDICES

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APPENDIX A

Services for Individuals with Complex Medical Support Needs

by

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Introduction/Overview

As in all previous reports to the Court, the Independent Reviewer continues to examine the supports provided to a cohort of individuals with complex needs. In the eighteenth review period, individuals with a developmental disability and complex medical support needs were reviewed. This period's Individual Services Review (ISR) Study focuses on a similar group of people. The Department of Behavioral Health and Disability Services (DBHDS) completed Quality Service Reviews (QSRs) of 400 individuals from November 2021 through May 2022; a cohort of 57 had complex medical needs based on their individual Supports Intensity Scale (SIS) scores of level 6. To determine findings related to these 57 individuals, 32 men and women were randomly selected to be reviewed by the Independent Reviewer's team of nurse consultants, using the same Monitoring Questionnaire as in prior studies. A sample size of 32 individuals was determined adequate for all the Study's findings to be generalized to the cohort with a 90% confidence level.

These men and women live throughout the Commonwealth; all Regions are represented. They reside in family homes, sponsor homes and group homes. Most importantly, each of these individuals was included in Round 3 of the Commonwealth's Quality Services Review, which reviewed services that occurred during the lookback period of January through June 2021.

This twenty-first review period's ISR Study again evaluates whether the Commonwealth's QSR consultants and process are sufficient to meet the requirements of Provision **V.I. 1**. Compliance Indicator 51.4 c. and Provision **V.I.2**., Compliance indicator 52.1 a. and c. These Compliance Indicators require that:

V.I. 1 The QSRs assess on a provider level whether:

51.4 c. Providers keep service recipients safe from harm, and access treatment for service recipients as necessary.

V.I. 2 The QSRs assess on an individual service recipient-level and individual provider-level whether:

52.1 a. Individuals' needs are identified and met, including health and safety consistent with the individual's desires, informed choice, and dignity of risk.

52.1 c. Services are responsive to changes in individual needs (where present) and service plans are modified in response to new or changed service needs and desires to the extent possible.

In analyzing the findings from the ISR Monitoring Questionnaire used by the nurse consultants, comparisons were made with the findings from the QSR evaluations of the same individuals and for the same period. The ISR findings were compared with the QSR consultants' findings to determine whether, and the extent to which, there were any discrepancies. As a result of this comparative analysis, the status of the Commonwealth's achievement with the QSR Compliance Indicators referenced above could be assessed, at least in part.

Prior to initiating the Study, the draft methodology was discussed with key staff from DBHDS. The Commonwealth was asked to identify and provide the contact information for the individuals to be reviewed, all documents relied upon in the QSR process and the QSR findings for each person in the sample.

Between September 6 and October 25, 2022, one nurse consultant and the Team Leader conducted the interviews by conference call. Responses to the Monitoring Questionnaire were documented by each nurse consultant and the data were aggregated and analyzed. Copies of the completed Monitoring Questionnaires will be provided to the Parties. By March 31, 2023, DBHDS is scheduled to report to the Independent Reviewer the actions and resolutions of any individual concerns/issues identified on the Issues Page in each Monitoring Questionnaire.

There were several constraints to an effective review identified throughout the course of this ISR Study. First, numerous requested documents were not provided or were not provided in a timely manner. As a result, some interviews were conducted without the benefit of reviewing the individual's information beforehand and some health-related information was not available at all. Second, follow-up information requested during the interview was not always provided to the nurse consultant. Third, although most residential contacts interviewed were knowledgeable about the individual and their health-related supports, particularly when it was a family member, some contacts had difficulty answering questions with accuracy or sufficient detail. If the individual being reviewed was no longer supported by the residential contact or if there had been staff turnover, some information might not be remembered or retrievable.

Therefore, it is possible that certain identified discrepancies in the respective findings were not actually discrepancies in fact but were the result of inconsistent sources of information.

DBHDS has informed the Independent Reviewer that it has already taken action to resolve these constraints in future studies. Among other adjustments, it is agreed that there will be an earlier timeframe for selection of the sample and the submission of the document request. These changes should be very helpful and certainly will expedite the work to be completed. Furthermore, it is important to acknowledge that DBHDS leadership responded as quickly as possible and to the extent possible when notified of these problems during the Study itself. This thoughtful responsiveness is greatly appreciated as is the willingness to modify procedures in anticipation of future work.

Finally, the nurse consultants and the Team Leader wish to express their thanks to the agency providers and the family members who participated in the interviews. Because this is a retrospective review, it took extra effort to respond to the health-care questions from the previous year.

Summary of Findings

The findings from this discrepancy study are recorded as follows:

- The Monitoring Questionnaires completed for everyone in the sample will be provided to the Parties. A person-by-person comparison of the findings from the Independent Reviewer's nurse consultant and the QSR Auditor, organized by Compliance Indicator, is highlighted in Attachment A. Additional detail may be found, if indicated, on the Issues Page of the Monitoring Questionnaire. It should be noted that the Issues Page is divided into two sections. The upper section of this Page documents health-related concerns, such as the lack of dental care, that should be recognized as deficient practice, even by a QSR Auditor who is not a clinician. The lower section of this Page outlines clinical observations or recommendations that should be within the scope of experience of a healthcare professional, such as the clinicians who are requested to conduct a clinical review in the QSR process.
- The charts below summarize the findings according to the specific language of the Compliance Indicators evaluated through this Study.

The Independent Reviewer's nurse consultants and the QSR Auditors concurred that there were ten people (Individual # 5, 8, 12, 15, 17, 19, 23, 24, 28 and 32) in the sample (31%) who raised no concerns about risk of harm or a lack of needed services/supports. Of the remaining 22 individuals (69%), the QSR Auditors identified the same concern as the ISR nurse for 1 of the 2 individuals at risk of harm, 1 of the 7 individuals who needed assessments or consultations, 4 of the 15 individuals who needed dental care, and 3 of the 5 individuals who needed modifications to the Individual Support Plan (ISP) because of a change in status.

21st Review Period Findings			
V.I. 1 The QSRs assess on a provider level whether: **51.04 c. Providers keep service recipients safe from harm, and access treatment for service recipients as necessary**	**Unmet health care need or safety from harm concern identified in ISR study (# of individuals)**	**Did the QSR consultants identify this healthcare need or safety concern?**	**Conclusion:**
	The ISR reviews identified 2 individuals who were not protected from potential risk of harm (Individuals # 11, 14: 6%).	The QSR reviewers identified 1 of 2 individuals (50%) who were at risk of harm.	Based on the documents available for review, the QSR Auditor failed to identify the lack of protocols for one person (#11) with risks of harm.

21st Review Period Findings			
V.I. 2 The QSRs assess on an individual service recipient-level and individual provider-level whether: **52.1 a. Individuals' needs are identified and met, including health and safety consistent with the individual's desires, informed choice, and dignity of risk.**	**Issue identified in ISR study (# of individuals):**	**Did the QSR consultants identify this Issue?**	**Conclusion:**
	The ISR reviews determined that 7 individuals needed assessments or consultations that were not recommended or ordered (Individuals # 7, 9, 11, 16, 21, 29, 31: 22%). The ISR reviews determined that individuals (15) lacked access to dental care (Individuals # 1, 2, 3, 6, 9, 10, 11, 16, 18, 20, 22, 25, 27, 29, 30: 47%). The ISR reviews found that necessary lab tests were completed timely for <u>all</u> relevant individuals with documentation provided.	The QSR Auditors identified 1 of these individuals (14%) who needed assessments. The QSR Auditors identified 4 of these15 individuals (27%) who needed dental care. The QSR Auditors' findings also did not cite any delayed lab work.	Based on the documents available for review, the QSR Auditors failed to identify all needed assessments or consultations for 6 of these individuals (86%). Based on the documents available for review, the QSR Auditors failed to identify needed dental care for 11 individuals (73%).

21st Review Period Findings			
V.I.2 The QSRs assess on an individual service recipient-level and individual provider-level whether: **1.c. Services are responsive to changes in individual needs (where present) and service plans are modified in response to new or changed service needs and desires to the extent possible.**	**Issue identified in ISR study (# of individuals):** The ISR reviews identified that the ISPs for 5 individuals required modification (Individuals # 6, 9, 11,19, 21) due to a change in status but that only 3 ISPs were modified (Individuals # 6, 9, 19: 60%).	**Did the QSR consultants identify this Issue?** The QSR Auditors did not identify that 2 ISPs (#11 and # 21) were not modified as expected.	**Conclusion:** Based on the documents available for review, the QSR consultants failed to identify that ISPs were not modified as expected for 2 of the 5 individuals (40%).

This ISR Study also examined the number of nursing hours assigned and provided for certain individuals in the sample. There were six people, as noted below, authorized to need and receive nursing hours during the timeframe for this review. DBHDS was requested to provide these data and they responded very promptly.

Nursing Hours Utilized			
ID#	**Authorization End Date**	**Percent Utilized**	**Meets 80% Utilization**
1	3/16/21	94.88%	Met
7	3/31/21	84.32%	Met
9	1/31/21	35.16%	Not Met
9	4/22/21	6.42%	Not Met
19	2/28/21	22.04%	Not Met
27	2/28/21	54.65%	Not Met
28	9/22/21	77.10%	Not Met

These findings are reported because of the requirement in Provision **III.D.1**., Compliance Indicator 18. 9 requiring that "individuals who have these services identified in their ISP…must have these services delivered…eighty percent of the time." In these cases, that standard was met for only two people (Individuals 1, 7). An explanation was provided to the ISR nurse consultant in the case of Individual # 9. Although nursing hours were authorized, his mother described the difficulties in recruiting and retaining nursing personnel. As a result, to receive some assistance, she has retained a Personal Care Attendant instead. Although her son needs the services of a skilled clinician to improve his physical strength and movement, she is relieved that she at least has a dependable resource available.

ATTACHMENT A
CHART ONE

Name	Compliance Question: Do providers keep service recipients safe from harm?	Response
#1	QSR Auditor answered ISR Nurse answered Issue identified, if ISR nurse answered No: There were no issues identified.	Yes ☒ No ☐ Yes ☒ No ☐
#2	QSR Auditor answered ISR Nurse answered Issue identified, if ISR nurse answered No: There were no issues identified.	Yes ☒ No ☐ Yes ☒ No ☐
#3	QSR Auditor answered ISR Nurse answered Issue identified, if ISR nurse answered No: There were no issues identified.	Yes ☒ No ☐ Yes ☒ No ☐
#4	QSR Auditor answered ISR Nurse answered Issue identified, if ISR nurse answered No: There were no issues identified.	Yes ☒ No ☐ Yes ☒ No ☐
#5	QSR Auditor answered ISR Nurse answered Issue identified, if ISR nurse answered No: There were no issues identified.	Yes ☒ No ☐ Yes ☒ No ☐
#6	QSR Auditor answered ISR Nurse answered Issue identified, if ISR nurse answered No: There were no issues identified.	Yes ☒ No ☐ Yes ☒ No ☐
#7	QSR Auditor answered ISR Nurse answered Issue identified, if ISR nurse answered No: There were no issues identified.	Yes ☒ No ☐ Yes ☒ No ☐
#8	QSR Auditor answered ISR Nurse answered Issue identified, if ISR nurse answered No: There were no issues identified.	Yes ☒ No ☐ Yes ☒ No ☐

#9	QSR Auditor answered ISR Nurse answered Issue identified, if ISR nurse answered No: There were no issues identified.	Yes ☒ No ☐ Yes ☒ No ☐
#10	QSR Auditor answered ISR Nurse answered Issue identified, if ISR nurse answered No: There were no issues identified.	Yes ☒ No ☐ Yes ☒ No ☐
#11	QSR Auditor answered ISR Nurse answered Issue identified, if ISR nurse answered No: The ISP notes that he has risk factors for pressure injury, bowel obstruction, aspiration pneumonia and dehydration. The plan is to refer to the primary care physician. There was no documentation as to how these issues are being addressed. None of these problems were reported in the interview. No protocols to address them are contained in the record.	Yes ☒ No ☐ Yes ☐ No ☒
#12	QSR Auditor answered ISR Nurse answered Issue identified, if ISR nurse answered No: There were no issues identified.	Yes ☒ No ☐ Yes ☒ No ☐
#13	QSR Auditor answered ISR Nurse answered Issue identified, if ISR nurse answered No: There were no issues identified.	Yes ☒ No ☐ Yes ☒ No ☐
#14	QSR Auditor answered ISR Nurse answered Issue identified, if ISR nurse answered No: Due to self-injurious behavior, REACH recommended, on January 13, 2021, that she requires the services of a behavioral specialist and the therapeutic services of a psychotherapist and/or trauma informed therapist. These services were not provided. The QSR auditor reported that there were no behavioral needs identified.	Yes ☒ No ☐ Yes ☐ No ☒
#15	QSR Auditor answered ISR Nurse answered Issue identified, if ISR nurse answered No: There were no issues identified.	Yes ☒ No ☐ Yes ☒ No ☐
#16	QSR Auditor answered ISR Nurse answered Issue identified, if ISR nurse answered No: There were no issues identified.	Yes ☒ No ☐ Yes ☒ No ☐

#17	QSR Auditor answered ISR Nurse answered Issue identified, if ISR nurse answered No: There were no issues identified.	Yes ☒ No ☐ Yes ☒ No ☐
#18	QSR Auditor answered ISR Nurse answered Issue identified, if ISR nurse answered No: There were no issues identified.	Yes ☒ No ☐ Yes ☒ No ☐
#19	QSR Auditor answered ISR Nurse answered Issue identified, if ISR nurse answered No: There were no issues identified.	Yes ☒ No ☐ Yes ☒ No ☐
#20	QSR Auditor answered ISR Nurse answered Issue identified, if ISR nurse answered No: There were no issues identified.	Yes ☒ No ☐ Yes ☒ No ☐
#21	QSR Auditor answered ISR Nurse answered Issue identified, if ISR nurse answered No: There were no issues identified.	Yes ☒ No ☐ Yes ☒ No ☐
#22	QSR Auditor answered ISR Nurse answered Issue identified, if ISR nurse answered No: There were no issues identified.	Yes ☒ No ☐ Yes ☒ No ☐
#23	QSR Auditor answered ISR Nurse answered Issue identified, if ISR nurse answered No: There were no issues identified.	Yes ☒ No ☐ Yes ☒ No ☐
#24	QSR Auditor answered ISR Nurse answered Issue identified, if ISR nurse answered No: There were no issues identified.	Yes ☒ No ☐ Yes ☒ No ☐
#25	QSR Auditor answered ISR Nurse answered Issue identified, if ISR nurse answered No: There were no issues identified.	Yes ☒ No ☐ Yes ☒ No ☐
#26	QSR Auditor answered	Yes ☒ No ☐

	ISR Nurse answered Issue identified, if ISR nurse answered No: There were no issues identified.	Yes ☒ No ☐
#27	QSR Auditor answered ISR Nurse answered Issue identified, if ISR nurse answered No: There were no issues identified.	Yes ☒ No ☐ Yes ☒ No ☐
#28	QSR Auditor answered ISR Nurse answered Issue identified, if ISR nurse answered No: There were no issues identified.	Yes ☒ No ☐ Yes ☒ No ☐
#29	QSR Auditor answered ISR Nurse answered Issue identified, if ISR nurse answered No: There were no issues identified.	Yes ☒ No ☐ Yes ☒ No ☐
#30	QSR Auditor answered ISR Nurse answered Issue identified, if ISR nurse answered No: There were no issues identified.	Yes ☒ No ☐ Yes ☒ No ☐
#31	QSR Auditor answered ISR Nurse answered Issue identified, if ISR nurse answered No: There were no issues identified.	Yes ☒ No ☐ Yes ☒ No ☐
#32	QSR Auditor answered ISR Nurse answered Issue identified, if ISR nurse answered No: There were no issues identified.	Yes ☒ No ☐ Yes ☒ No ☐

ATTACHMENT A
CHART TWO

Name	Compliance Question: Are individuals' needs identified and met?	Response
#1	QSR Auditor answered ISR Nurse answered Issue identified, if ISR nurse answered No: The individual's dental examination occurred a little more than a year ago, according to the staff person. The individual had to change dentists; a new one who will take her insurance has not yet been found. The staff person reported that the individual has protocols for aspiration/feeding, fluids, seizures, and positioning. A fall risk assessment has been done. The QSR cited these issues.	Yes ☐ No ☒ Yes ☐ No ☒
#2	QSR Auditor answered ISR Nurse answered Issue identified, if ISR nurse answered No: No dental exam since March 8, 2017. A provider has not been identified who can administer appropriate sedation.	Yes ☒ No ☐ Yes ☐ No ☒
#3	QSR Auditor answered ISR Nurse answered Issue identified, if ISR nurse answered No: There was no dental exam.	Yes ☒ No ☐ Yes ☒ No ☐
#4	QSR Auditor answered ISR Nurse answered Issue identified, if ISR nurse answered No: The individual fell and broke three teeth in January 2020. He saw a dentist for extraction of the broken teeth. The records reviewed do not indicate any dental visits since that time. The records reviewed do not provide a fall risk protocol, although a fall risk assessment has been done. The individual has choking precautions, but the records did not contain an aspiration/feeding protocol. The QSR identified problems with falls, choking/aspiration, turning and positioning and pressure/skin integrity.	Yes ☐ No ☒ Yes ☐ No ☒
#5	QSR Auditor answered ISR Nurse answered Issue identified, if ISR nurse answered No: There were no issues identified.	Yes ☒ No ☐ Yes ☒ No ☐
#6	QSR Auditor answered ISR Nurse answered Issue identified, if ISR nurse answered No: The individual has several significant medical diagnoses: congestive heart failure, pressure sores, seizure disorder, a PEG tube, choking precautions, non-ambulatory, and is on several psychotropic and anti-	Yes ☐ No ☒ Yes ☐ No ☒

	convulsant medications. He had an unplanned medical hospitalization in February 2021, following a COVID infection. At that time, he was intubated and treated for hypokalemia and malnutrition. Although he is edentulous, the records reviewed do not indicate that he has had an oral examination since January 3, 2019. A health care professional should examine the oral structures at least annually to ensure that there are no disease processes. The QSR identifies that he has "exceptional health needs" and requires a "clinical review."	
#7	QSR Auditor answered ISR Nurse answered Issue identified, if ISR nurse answered No: The individual spends most weekends at home with his family. While there, he eats food orally although he is NPO in his group home. The staff person reported that he has had two swallow studies, one of which recommended pleasure feeding as a possibility but the second one ruled out any oral feeding. While in the program, he is fed through a g-tube, He has had the g-tube since 2019. He is underweight with a BMI of 15.6 (healthy range is 18.5-24.9), which is an additional health care problem. He has pressure sores and is on a positioning schedule while at the program. When he is home with his family, he remains in his wheelchair, including sleeping in the chair all night. Because of his time spent in the wheelchair at home, he will return from home with edema of the upper extremities. The staff reported that DBHDS assisted the family with the proper equipment, but it is either not present or used. He has behaviors of tantrums, thrashing about and hitting walls and other objects. He would benefit from a psychological/psychiatric assessment to determine whether a behavior plan or other treatment modalities would help alleviate these behaviors. He has had multiple urinary tract infections, nearly consistently from January-May 2021. He was seen by a urologist, who has recommended five times daily straight catheterizations, but his guardian has declined this specialist's recommendation. The provider program is implementing services and recommendations, but these are not carried out when he is out of the program. The continued non-compliance when he is at home is a potential risk of harm due to the risk of aspiration, unhealthy weight, pressure sores and frequent urinary tract infections. The QSR noted that the ISP did not document medical needs in Part III and that support needs are not being met.	Yes ☐ No ☒ Yes ☐ No ☒
#8	QSR Auditor answered ISR Nurse answered Issue identified, if ISR nurse answered No: There were no issues identified.	Yes ☒ No ☐ Yes ☒ No ☐
#9	QSR Auditor answered ISR Nurse answered Issue identified, if ISR nurse answered No: The inability to obtain consistent nursing care resulted in a change to a Personal Care Attendant (PCA). He has not had a dental assessment since August 29, 2019, due to the inability to find a dentist willing to provide care because of his tracheostomy and use of a ventilator. He is losing feeling in his	Yes ☒ No ☐ Yes ☐ No ☒

	hands and lower body but has not had a current PT or OT evaluation to determine and implement a plan to promote his movement and minimize/slow down the deterioration.	
#10	QSR Auditor answered ISR Nurse answered Issue identified, if ISR nurse answered No: The last dental examination was December 1, 2019. Documentation stated that she requires sedation and approval would be needed from a neurologist. However, according to the ISP, the assessment had not been obtained. The QSR stated that she had dental assessments annually but that could not be verified because the documents were not provided for the ISR.	Yes ☒ No ☐ Yes ☐ No ☒
#11	QSR Auditor answered ISR Nurse answered Issue identified, if ISR nurse answered No: His mother requested assistance in improving communication skills. There was no evidence that this need had been addressed. There was no dental exam.	Yes ☒ No ☐ Yes ☐ No ☒
#12	QSR Auditor answered ISR Nurse answered Issue identified, if ISR nurse answered No: There were no issues identified.	Yes ☒ No ☐ Yes ☒ No ☐
#13	QSR Auditor answered ISR Nurse answered Issue identified, if ISR nurse answered No: The individual has minimal ability to direct her own care and must depend on others to ensure her health and safety. At the direction of the guardian/family member, the provider does not accompany the individual to any physician visits or receive any laboratory or diagnostic studies from visits. The agency receives a copy of the written summary from the physician visit and a copy of any physician orders. The provider was told by the family not to call 911 in case of an emergency but to call the family instead. The inability for the provider to work directly and collaboratively with medical professionals and the family, at minimum, creates the potential for medical errors due to the lack of information and conflict in care of the individual. The QSR noted that the RAT was not filled out timely, that the ISP did not include the RAT and that the side effects of medications were not noted in the ISP.	Yes ☐ No ☒ Yes ☐ No ☒
#14	QSR Auditor answered ISR Nurse answered Issue identified, if ISR nurse answered No: The services recommended by REACH have not been provided. The QSR Auditor reported there were no behavioral support needs identified despite her self-injurious behavior.	Yes ☒ No ☐ Yes ☐ No ☒
#15	QSR Auditor answered	Yes ☒ No ☐

	ISR Nurse answered Issue identified, if ISR nurse answered No: There were no issues identified.	Yes ☒ No ☐
#16	QSR Auditor answered ISR Nurse answered Issue identified, if ISR nurse answered No: The individual has not had an annual physical examination since December 12, 2019, and the last dental examination was September 11, 2017. The individual is confined to her bed with a goal to be out of bed for 20 minutes a day. It is not clear from the records reviewed or from the interview why she cannot be out of bed for longer periods of time. Staff interviewed stated that she cannot be out of bed for more than 20 minutes daily due to an autoimmune disorder, but they could not describe the disorder with any more specificity and the records reviewed did not indicate that there is any autoimmune disorder. The individual receives all nutrition from PediaSure, six to seven cans daily, through a bottle. Her weight is 74 pounds, and she is four feet eight inches tall, which places her BMI at 16.6. She is underweight with a healthy range of 18.5-24.9. It is not clear from the records reviewed, and the interview with staff, what is preventing her from a different form of nutrition. She has a nutritional management plan and a feeding safety protocol from her physician dated December 10, 2021. The staff interviewed stated that she has never received food and that there is a possible history of a feeding disorder in infancy and early childhood. There is no record of any swallowing studies being performed. There are no laboratory studies in the records reviewed and the staff interviewed stated that they did not know if laboratory studies were ordered by the physician. Laboratory studies could provide information about her nutritional status and/or other health concerns. The QSR noted that she did not have an up-to-date physical examination or dental examination. It noted that the ISP does not list all identified health needs and that a clinical review is needed.	Yes ☐ No ☒ Yes ☐ No ☒
#17	QSR Auditor answered ISR Nurse answered Issue identified, if ISR nurse answered No: There were no issues identified.	Yes ☒ No ☐ Yes ☒ No ☐
#18 DG	QSR Auditor answered ISR Nurse answered Issue identified, if ISR nurse answered No: There was no dental exam.	Yes ☒ No ☐ Yes ☒ No ☐
#19	QSR Auditor answered ISR Nurse answered Issue identified, if ISR nurse answered No: There were no issues identified.	Yes ☒ No ☐ Yes ☒ No ☐
#20	QSR Auditor answered	Yes ☒ No ☐

	ISR Nurse answered Issue identified, if ISR nurse answered No: Although the individual is edentulous, there is no evidence found in the records reviewed that any health care professional has examined her oral structures for any disease process. Her last dental examination was in 2018.	Yes ☐ No ☒
#21	QSR Auditor answered ISR Nurse answered Issue identified, if ISR nurse answered No: The individual has had several changes in provider agencies over the period reviewed, at least two in six months. The records reviewed indicated there had been other providers over the past year or so. The staff person interviewed stated that a psychological assessment is needed to help understand the difficulty with staff refusing to continue to work with him. The staff person reported that there were many conversations with the service coordinator to resolve this issue. The records reviewed do not document any team meetings to address this problem. The potential lack of in-home supports places the individual at risk for a nursing home placement. The QSR documents that the ISP does not identify exceptional medical needs of lifting and transferring, inhalation or oxygen therapy or fall risk. The RAT was not done timely. The QSR recommends a clinical review.	Yes ☐ No ☒ Yes ☐ No ☒
#22	QSR Auditor answered ISR Nurse answered Issue identified, if ISR nurse answered No: There is a discrepancy in the date of the last dental assessment between the ISP and the QSR. The ISP stated that the last dental exam was on February 2, 2017. The QSR stated it was completed on January 24, 2019.	Yes ☒ No ☐ Yes ☐ No ☒
#23	QSR Auditor answered ISR Nurse answered Issue identified, if ISR nurse answered No: There were no issues identified.	Yes ☒ No ☐ Yes ☒ No ☐
#24	QSR Auditor answered ISR Nurse answered Issue identified, if ISR nurse answered No: There were no issues identified.	Yes ☒ No ☐ Yes ☒ No ☐
#25	QSR Auditor answered ISR Nurse answered Issue identified, if ISR nurse answered No: According to the sponsor interview, the individual has not seen a dentist in approximately five years. The individual does not have the type of dental insurance required by dentists in her area. The ISP states that the individual has gingivitis and should see a dentist every three months. The primary caregiver provides oral hygiene twice daily.	Yes ☒ No ☐ Yes ☐ No ☒
#26	QSR Auditor answered ISR Nurse answered	Yes ☐ No ☒ Yes ☒ No ☐

	Issue identified, if ISR nurse answered No: The QSR identified the concern that the last dental assessment was October 2, 2017. However, she is edentulous, and the primary care physician completed an oral exam on August 28, 2020. That exam is sufficient according to generally accepted practice.	
#27	QSR Auditor answered ISR Nurse answered Issue identified, if ISR nurse answered No: There was no dental exam.	Yes ☒ No ☐ Yes ☒ No ☐
#28	QSR Auditor answered ISR Nurse answered Issue identified, if ISR nurse answered No: There were no issues identified.	Yes ☒ No ☐ Yes ☒ No ☐
#29	QSR Auditor answered ISR Nurse answered Issue identified, if ISR nurse answered No: There was no dental exam. The individual is underweight (low 80# range) and has had difficulty gaining weight. He should have a nutritional assessment to determine an appropriate weight and a nutritional plan then should be developed to address his needs. He is taking two psychotropic medications for anxiety and property destruction but has no behavior support plan. A behavioral assessment is needed to determine if a behavior support plan would be beneficial. According to his ISP, he has a diagnosis of tardive dyskinesia (TD), which resulted in the placement of a gastrostomy tube in 2017. It was reported that he no longer has signs of TD, does not take any medications for TD, and the psychiatrist does not administer any standardized test for TD. There should be a neurological assessment to determine whether TD is an accurate, current diagnosis. If so, he should have routine standardized testing. If it is accurate that there are no longer any symptoms of TD, he should have a mealtime evaluation to determine whether tube feeding is still necessary. The QSR identified the need for staff to be trained in catheter and gastrostomy tube care, that a catheter protocol be developed and implemented, and that consideration be given to move him to a residence that could more adequately meet his needs. Those issues were resolved.	Yes ☐ No ☒ Yes ☐ No ☒
#30	QSR Auditor answered ISR Nurse answered Issue identified, if ISR nurse answered No: There has not been a dental exam in five years, although the Primary Care Physician does check for bleeding gums during the annual visit. The QSR Auditor identified the out-of-date dental care and reported that there was a concern that required follow-up; a clinical review was requested. However, under TA, it was reported that no TA was needed because she is non-verbal.	Yes ☐ No ☒ Yes ☐ No ☒
#31	QSR Auditor answered	Yes ☒ No ☐

	ISR Nurse answered Issue identified, if ISR nurse answered No: The individual is immobile and relies upon a wheelchair and other adaptive equipment but would benefit from a physical therapy assessment. The sponsor specifically requested assistance with lifting techniques and equipment and with providing the individual with appropriate exercises to maintain functional abilities. The QSR did not identify this need but did identify that the RAT was not done timely and incorporated into the ISP.	Yes ☐ No ☒
#32	QSR Auditor answered ISR Nurse answered Issue identified, if ISR nurse answered No: There were no issues identified.	Yes ☒ No ☐ Yes ☒ No ☐

Demographics

Region		
I	5	15.6%
II	4	12.5%
III	6	18.8%
IV	7	21.9%
V	10	31.3%

Sex		
Male	21	65.6%
Female	11	34.4%

Age Group		
Under 21	2	6.3%
21-30	4	12.5%
31-40	9	28.1%
41-50	7	21.9%
51-60	3	9.4%
61-70	2	6.3%
71-80	5	15.6%

Mobility Status		
Walks without support	1	3.1%
Walks with support	24	75.0%
Uses wheelchair	5	15.6%
Confined to bed	2	6.3%

Residence Type		
Group home	12	37.5%
Own/family home	9	28.1%
Sponsored home	11	34.4%

APPENDIX B

Integrated Day Activities and Supported Employment

by

Katherine du Pree, MPS
Joseph Marafito, MS

2022 REVIEW OF THE INTEGRATED DAY SERVICES REQUIREMENTS OF THE US v COMMONWEALTH OF VIRGINIA'S SETTLEMENT AGREEEMENT

REVIEW PERIOD: OCTOBER 1, 2021– SEPTEMBER 30, 2022

SUBMITTED TO DONALD FLETCHER

INDEPENDENT REVIEWER

BY: KATHRYN DU PREE, MPS

EXPERT REVIEWER

October 28 , 2022

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I. Overview of Requirements

Donald Fletcher, the Independent Reviewer, has contracted with Kathryn du Pree as the Expert Reviewer to perform the review of the employment services requirements of the Settlement Agreement for the twenty-first review period 10/01/21– 9/30/22. The purpose of the review is to determine the Commonwealth's progress implementing plans to comply with the requirements of the Settlement Agreement focused on employment and integrated day activities (III.C.7.a.1; III.C.7.a.2; and III.C.7.b.) The report of integrated day services will review evidence that the Commonwealth has completed a legitimate process that has verified the accuracy of the Commonwealth's data and documentation of its efforts to achieve compliance with these Provisions and their associated 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 fourth review that covers a twelve-month period of time. 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 Sections III.C.7.a. and b. of the Settlement Agreement. 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 14.1 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 14.2 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 14.3 At least 50% of ISPs of individuals (age 18-64) who are receiving waiver services include goals related to employment.

CI 14.4 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 14.5 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 14.6 At least 86% of individuals who are receiving waiver services will have goals for involvement in their community developed in their annual ISP.

CI 14.7 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 14.8 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 14.9 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. Purpose of the Review

This review will build off the review completed last fall by the Expert Reviewer for the eighteenth and nineteenth review periods, 10/01/20 through 9/30/21, and the related recommendations the Independent Reviewer made in his 19th Report to the Court on 12/13/21. The focus of this review is to determine Virginia's progress toward achieving 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 2022 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 Commonwealth's success in developing and verifying reliable and valid processes for collecting and analyzing the data that are relevant to each of the Compliance Indicators (CI) relevant to this review of integrated day activities provided during the twentieth and twenty-first review periods referred to as Year 7 throughout the remainder of this report.

III. 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 staff of DBHDS, and members of the Employment First Advisory Group (E1AG), previously known as the SELN-Virginia. In July 2022, prior to initiating this review, a kickoff meeting was held with the Independent Reviewer, the Expert Reviewer, Heather Norton, Eric Williams, 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 CIs 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. We reviewed the methodology that DBHDS is using to verify that its documents and reports include reliable data; 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. The methodology used to compile this report 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.

Document Review: Documents reviewed include:

1. VA DBHDS Employment First Plan: FY2020-2023 Update
2. DBHDS Semiannual report on Employment (through 12/31/21)
3. DBHDS Semiannual report on Employment (through 06/30/22)
4. Regional Quality Council (RQC) meeting minutes and recommendations for implementing Employment First
5. Employment First Advisory Group (E1AG) meeting minutes
6. Community Engagement Advisory Group (CEAG) meeting minutes
7. CEAG Work Plan
8. Support Coordinator Quality Reviews Methodology and Supporting Processes and Draft Reports for FY22
9. CSB Performance Letters (*CIs 14.2-14.6*)
10. Provider Data Summary Report May 2022 (version 7/21/22)
11. CMSC Report FY22 1st and 2nd Quarters
12. CMSC Report FY22 3rd and 4th Quarters
13. Process Documents
14. Monitoring Questionnaire for Data Verification for *CIs 14.2,14.3,14.4, 14.5,14.6,14.7, 4.8, 14.9 and 14.10* developed for FY22 data
15. ISP and related documents for 98 individuals in the SCQR sample

As noted above, the documents include the data summary of the retrospective review completed by the Office of Community Quality Improvement (CQI) staff and a review of 98

of the 100 ISPs (two records were not provided), that were reviewed by CQI staff for the Service Coordinator Quality Retrospective (SCQR)review for FY22 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 CSB review process. The study is further detailed, and the findings are presented in a separate report titled: *Integrated Day Activities Qualitative Study for the 21st Review Period,* which was submitted to the Independent Reviewer. It is included as an Attachment to this report.

Interviews: The Expert Reviewer interviewed members of the E1AG some who are also members of the CEAG; Heather Norton, Assistant Commissioner, Developmental Services, DBHDS; Eric Williams Director of Provider Development, DBHDS; and Linda Bassett DBHDS Waiver Projects Administrator**.**

I appreciate everyone's willingness to participate in interviews and for the work of DBHDS staff to share numerous individual plans and reports. All the interviews provided information that contribute to a more robust report. The graphs in this report are taken from DBHDS' Semiannual Employment Report through June 2022.

IV. 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 activities it plans to engage in to achieve the desired outcomes. The DBHDS did include a status report of progress towards implementing the activities or meeting the benchmarks. Below is a summary of the Project Plan.

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

Updates for FY22 Q2-Q4: DBHDS and DARS continue to participate in the ASPIRE National Learning Community. The ASPIRE initiative has sent out a survey to providers to gauge

their interest in the IPS Supported Employment Program and the NTACT work group is developing materials for virtual town hall meetings. Regional initiatives are shared. This initiative is funded by Office of DisAbility Policy (ODEP), US Department of Labor, to provide technical assistance to improve individual placement support for individuals with SMI or co-occurring SMI/DD.

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.)

Updates for FY22 Q2-Q4: the employment module for CM training has been updated; the E1AG has sent a survey to all stakeholders and used the feedback to finalize the training outline document incorporating peer specialists in the employment support model.

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

No updates were provided as needed data has not been received.

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

Updates for FY22 Q2-Q4: Provided training for IPS and Peer Recovery; addressed bridging gaps in peer recovery for employment support; and developed recovery-oriented Employment Services (ROES).

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

Updates for FY22 Q2-Q4: sought additional applicants for E1AG membership

Conclusion and Recommendations

Based on interviews and a review of the training materials it is evident that both DBHDS and the E1AG continue to be involved in the activities of the Employment First Project Plan. There continues to be involvement of other state agencies on the E1AG. DBHDS and the E1AG continue to work on training and resource materials related to employment across the lifespan. The E1AG has a data sub-committee that continues to analyze employment data which is presented for analysis and recommendation to the full E1AG. Membership or the E1AG has been re-structured and continues to include members who can represent individual with mental and substance use conditions.

The Employment Plan was developed several years ago and has been updated with activities through FY23. Many of the Action Steps have been accomplished or are just ongoing activities with no specific outcome or performance measures. The E1AG should review and update the plan so it reflects current activity and sets annual timeframes for accomplishments to be achieved.

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. One summarizes December 2021 data and the other summarizes June 2022 data. The DBHDS Semiannual Report on Employment dated 10/12/2022 is the thirteenth 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. These data sources are used to determine the Commonwealth's compliance with CIs 14.8, 14.9 and 14.10. The analysis of the data collection and analysis processes and the validity of these data are discussed in a later section

Statewide Employment Data Analysis-This report compares the achievements in June 2021 to the achievements in employment in June 2022 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 2021 and June 2022.

Table 1: *Comparison of the Number of Individuals in ISE and GSE in June 2021 and June 2022*							
Funding Source	ISE Participant 0621	ISE Participant 0622	**ISE Change**	GSE Participant 0621	GSE Participant 0622	**GSE Change**	**Total Change of ISE and GSE**
Waiver	469	530	**61**	239	234	**-5**	**56**
EES	31	34	**3**	23	41	**18**	**21**
LTESS	1809	2454	**645**	15	28	**13**	**658**
Other	348	349	**1**	159	132	**-27**	**-26**
DARS	414	364	**-50**	1	4	**3**	**-47**
TOTAL	3071	3731	**660**	437	439	**2**	**662**

The data indicate increases in the number of individuals in Individual Supported Employment (ISE) services and in Group Supported Employment (GSE) services in June 2022 compared to June 2021. A total of 4,170 individuals (3,731 in ISE and 439 in GSE), were employed as of June 2022 compared to 3,508 who were employed twelve months earlier. The previous two years experienced decreases in employment: 9 fewer individuals were employed in June 2021, and 814 fewer individuals were employed in June 2020, compared to June 2019. Employment in the previous two reporting periods was significantly impacted by the COVID pandemic. It is heartening to report the increase in employment as of June 2022 when 662 more people with I/ DD had jobs then the year before. The increase of ISE participants is primarily in the LTESS program. Also, there was a 13% increase in employment for individuals in the waiver between June 2021 and June 2022.

These numbers reflect the total number of individuals reported as employed across all employment programs including the programs offered by DARS as well as the HCBS waiver employment services.

Overall, 4,170 people are employed with supports from ISE and GSE. The target set by the E1AG was that 4,960 individuals would be employed, which represents 25% of the 19,843 individuals on the waiting list as of 6/30/22. The number employed, 4,170, represents 21% 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 an increase from June 2021 when 16% of the target was met, and from June 2020 when 19% of the target was met.

The data indicates that 764 individuals on the waivers are employed of 13,528 adults on the waiver between the ages of 18 and 64. This is 6% of individuals on the waiver. In June 2021, 708 individuals on the waivers were employed representing (5%) of the 13,662 individuals who are waiver participants. Of the 764 individuals who were employed as of June 2022, 530 (69%) are employed through ISE and 234 (31%) are employed through GSE. Of all those employed, the percentage of the individuals in ISE has increased from 66% to 69% this year, compared to June 2021.

DBHDS has been able to sustain 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 competitively employed. Overall, of all the individuals in supported employment in June 2022 in either ISE or GSE, 89% were employed in ISE, compared to 87% in June 2021; 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 I/DD.

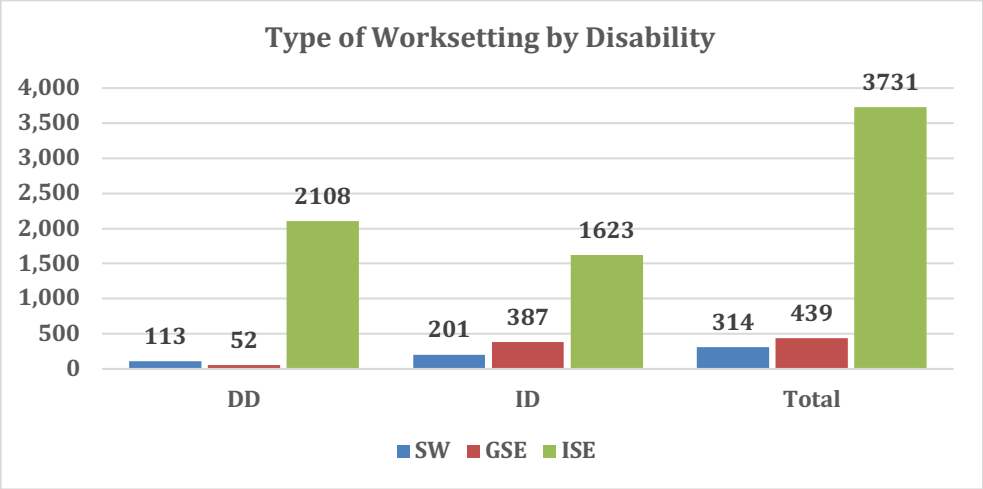
The number of individuals in the sheltered workshops (SW) is not counted by DBHDS towards the employment target goals. However, it is important to track the changes in utilization of the workshops. Fewer individual should be in SWs as a result of the changes DBHDS made in the waiver service definitions. 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. 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. It is encouraging to report that in June 2022 the participation in sheltered work has decreased to a total of 314 individuals. However, the number of individuals on the waiver who have only sheltered work increased from forty-eight in June 2021 to fifty-five in June 2022. DBHDS is committed to follow up with these individuals as noted in the Semiannual Employment Report June 2022.

Employment of ID and DD individuals Overall there is a 19% increase in the numbers of individuals employed in ISE with either ID or DD between June 2021 (3,071) and June 2022 (3,731) which is reflective of previous data presented in this report. Of the individuals employed through ISE, 2,108 (56%) have a DD and 1,623 (44%) have an ID. In June 2021 46% of the individuals in ISE had DD and 54% of these individuals have ID.

Between June 2021 and June 2022, the number of individuals with DD in ISE increased by 686, from 1422 to 2108 individuals, while the number of individuals with ID in ISE decreased slightly from 1649 to 1623 over the same time period. Employment for individuals with DD increased by 48%. This is the second year in which the increase in employment was enjoyed by individuals with DD. In June 2021 the DBHDS reported an increase of 15% of employed individuals with DD. 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 their 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 2022.

Graph 1: Type of Work by Disability



The data in the graph above compares employment settings by disability. It is from the DBHDS Semiannual Report on Employment June 2022

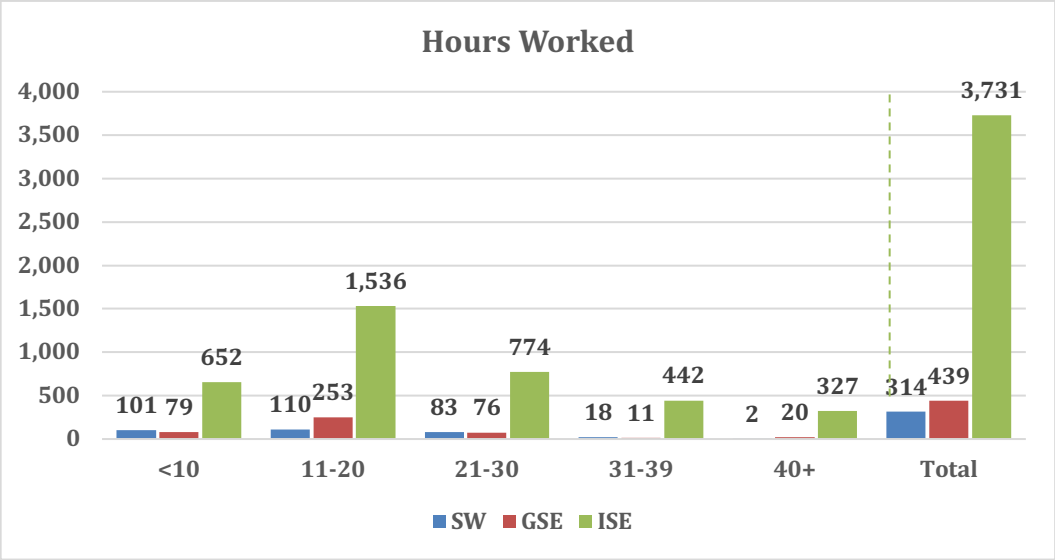
Average hours worked- The Commonwealth no longer reports on these data by ID and DD target groups. Previously individuals with DD worked more hours on average than did their counterparts with ID. Comparisons of both data sets have been useful in the past as they provide more detailed information about potential areas of underemployment and geographic disparities. This data would be important for the E1AG to review and analyze when comparing work opportunities for individuals with DD compared to those individuals with ID as I recommend above. **Graph 2** below details hours worked by service type in the DBHDS Semiannual Employment Report as of June 2022.

There has been an increase in the number of individuals who receive employment support whose wages are reported. More individuals are working more than thirty hours a week. However, for the first time in three years, the percentage of individuals who work twenty hours or less per week has increased to 68% (2,520) of the individuals employed, compared to the data from June 2021 and June 2020 when 56% of the total number of individuals employed worked twenty hours or fewer.

The percentage of individuals reporting working more than thirty hours per week is comparable to last year. Also, the number of individuals in ISE working either 31-39 or forty or more hours per week increased by 105 individuals from 695 in June 2021 to 800 in June 2022. 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 59% (2188 of 3,731 individuals in ISE) are working no more than twenty hours per week. This overall percentage is higher than it was in June 2021 and includes over 500 more individuals than in June 2021.

The data below depicts the hours worked by service type as of June 2022

Graph 2: Hours Worked



Graph 2 is from the DBHDS Semiannual Report on Employment June 2022

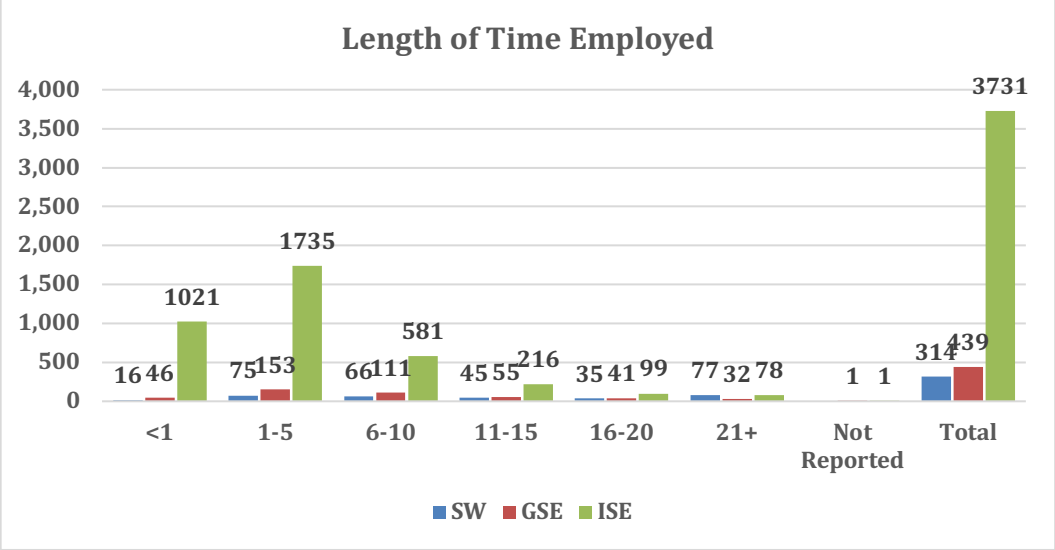
DBHDS now reports the type of employment services individuals receive by age. This graph was added in 2020 so that the E1AG could monitor transition age youth and employment choices they are making with the initiation of the Workforce Innovation and Opportunity Act. Of the 3,731 individuals in ISE as of June 2022, 900 (24%) are between the ages of 18 and 24. This percentage was 20% in June 2021 so there has been an increase over the past year.

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 those with 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 2022. Overall, 74% of all individuals employed worked at their job for one year or more. This is reflective that 73% of individuals in ISE held their jobs for twelve months or more compared to 87% in June 2020; and 90% of individuals in GSE in June 2022, compared to 90% of individuals in GSE in June 2021 who were employed in their job for more than twelve months. When one considers the 3731 individuals who are employed, the percentage of 74% does not meet the expectation of the SA. However, the increase of the number of individuals employed between June 2021 and June 2022 is 660. None of the newly hired individuals could have been employed for more than twelve months.

Subtracting this number from the total number reported as employed for less than twelve months results in 407 individuals reported in this category. This would indicate that of the 3071 individuals reported as employed in June 2021, 87% (2,664). However, it does not account for all the individuals who lost their jobs during the pandemic and who have not returned to work.

DBHDS also reports on the number of individuals in pre-vocational settings (sheltered work) and the length of time these individuals have been in these settings to respond to *7.b.i.B.1.d and e*. Unlike ISE and GSE, most of these individuals (36%) have been in a sheltered work setting for over fifteen years: thirty-five for 16-20 years and seventy-seven for over twenty years. This is a group of individuals who should have the opportunity to be supported in real work paying at least minimum wage for those who are not currently paid at this level.

Graph 3: Length of Time Employed



The above graph is from the DBHDS Semiannual Employment Report June 2022

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 2022. One hundred thirty-four individuals in ISE and GSE report earning less than minimum wage. DBHDS notes, however, that this may be

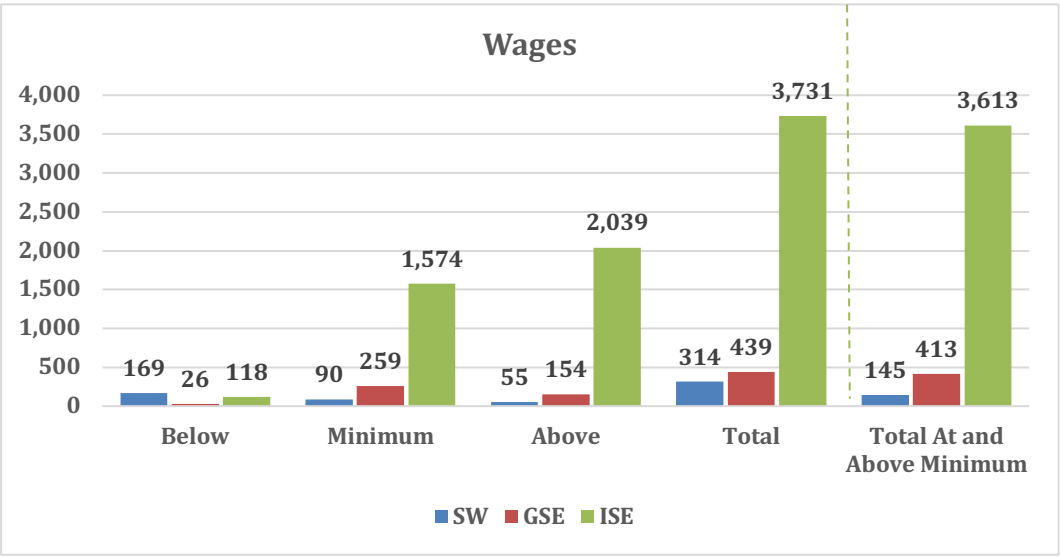
reported in error since the minimum wage has changed in Virginia. This data indicates 26 individuals in GSE and 118 individuals in ISE were earning less than minimum wage. This is

a substantial decrease from June 2021 when 913 individuals were reported earning less than the minimum wage.

Overall, 97% of individuals working in either ISE or GSE make at least minimum wage, compared to 48% on June 2020. The wages paid to individuals in ISE range from $7.36(plus tips) to $49.50. In GSE the range of wages paid in $0.57-$20.10.

The graph below depicts this data.

Graph 4: Wages



The above graph is from the DBHDS Semiannual Employment Report June 2022

Conclusion and Recommendations: The DBHDS is meeting 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.

V. 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 6/30/22, which was 19,483. Therefore, the Commonwealth commits to a total of 4,960 being employed as of June 30, 2022. However, the total number employed through ISE and GSE was 4,170 as of that date, representing 21% of the total number on the waivers or waiting lists. This percentage was 18% in June 2021, and 19% in June 2020 of the waiver and waiting list numbers. 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. The decline in the Commonwealth's achievement of the target is in large part attributable to COVID. It is noteworthy that the numbers of individuals employed in June 2022 compared to June 2021 increased overall by 662.

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 the previous reporting period, in large measure as a result of individuals losing employment during COVID 19. 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 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.

Table 3 depicts the overall employment changes in waiver programs from FY16- FY22. In the past five years an additional 305 individuals are employed in ISE programs. There is an overall decrease in the number of individuals employed in waiver programs of 126 because of a significant decrease in the number of individuals employed through GSE. The target for FY22 was to have 1211 individuals employed including 661 in ISE and 550 in GSE. Instead, there are only 764 individuals employed through HCBS waiver employment programs including 530 individuals in ISE and 234 individuals in GSE. DBHDS has been set back during this reporting period reaching only 63% of the target it set for the end of FY22. In comparison, DBHDS had reached 42% of the target at the end of FY21. While the Commonwealth did not meet its target, this is a significant increase as the state begins to recover from the COVID pandemic.

DBHDS has extended its employment initiative by three additional years to FY24 to achieve the targets originally set for FY21 for individuals to be employed using waiver programs. This reduced target was not reached for FY22.

Table 2 illustrates and compares the original targets to the revised targets set in 2019 and reflected in the June 2022 report as the continued targets set by the Commonwealth.

Table 2: Employment Targets for the HCBS Waiver Programs FY16-24							
End of FY	**Target Total**	**Actual Total**	**ISE Target**	**Actual ISE**	**GSE Target**	**Actual GSE**	**% of Total**
16	808	890	211	225	597	665	100%+
17	932	826	301	305	631	521	89%
18	1297	972	566	422	731	550	75%
19	1211	1078	661	555	550	523	89%
20	1486	715	936	480	550	235	48%
21	1685	708	1135	469	550	239	42%
22	1211	764	661	530	550	234	63%
23	1486		936		550		
24	1685		1135		550		

Table 3: Number of Individuals Employed in the HCBS Waiver Programs FY16-22			
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
22	530	234	764
Total Increase '16-'22	***+305***	***(-431)***	***(-126)***

Comparison of the Targets- As of June 2022 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 and met 89% of its target for employment in the waiver program. This year 21% of the total number of individuals enrolled in HCBS waivers or on the waiting list for these waivers were employed.

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. As of June 2022, only 63% of the target of 1211 individuals to be employed in either ISE or GSE through the waivers were working (764 individuals). Originally, the Commonwealth set employment targets through FY21. The target for FY21 was 1685, but as a result of COVID only 42% of this target was met. The Commonwealth has not met ***CI 14.8 or CI 14.9.***

DBHDS has lowered the numbers of people they project will be employed in FY23 and FY24 from the numbers that it set for FY21 and FY22. DBHDS has set the targets for the next two fiscal years to reflect the original projections for FY19 and FY20. This was done with the input and agreement of the E1AG recognizing the significant impact the COVID pandemic had on reducing employment for individuals with I/DD.

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*** 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 *employed* in ISE and GSE. In June 2019, 789 ISE and 555 GSE authorizations were approved versus 555 ISE and 523 GSE actual participants who were employed. The number of authorizations versus the number of actual participants for subsequent years follows a similar pattern The authorizations as of June 2022 were 674 for ISE, versus a target of 530 for ISE placements in this year; and was 309 authorizations for GSE compared to a target of 234 GSE placements. It is noteworthy that Virginia continues to make a financial commitment to employment for individuals on the HCBS waivers. However, it is not increasing its service authorizations as required by the SA and expressed in ***CI 14.10,*** which is discussed below.

The Semiannual Employment Reports of December 2021 and June 2022 include data regarding new service authorizations. These data respond to ***CI 14.4*** that requires 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 sixty days. The data provided in the December report indicates that 112 individuals had new authorizations for employment services between 7/1/21 and 12/31/21. Of these 112 individuals, 17 were authorized after 11/5/21, so had not yet experienced 60 days from the date of service authorization when the data was analyzed on 12/31/21. Of the remaining 95 individuals, 61 started services as evidenced by billing clams. This indicates that 64% of the individuals started employment services within the 60 days of service authorization.

The data provided in the June report indicates that 93 individuals had new authorizations for employment services between 1/2/22 and 6/30/22. Of these 93 individuals, 38 were authorized after 5/5/22, so had not yet experienced sixty days from the date of service authorization when the data was analyzed on 6/30/22. Of the remaining 55 individuals, 47 started services as evidenced by billing clams. This indicates that 85% of the individuals started employment services within the sixty days of service authorization. In total for the

year only 108 (72%) of 150 individuals with a service authorization for employment started the service within sixty days. The Commonwealth has again not met the requirements of ***CI 14.4.***

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 assisting providers to determine how to employ sufficient job coaches and job development staff in this time of unprecedented staff shortages. DBHDS must continue to work with CSBs to ensure CMs are adequately trained to discuss employment in a meaningful way and are aware of all the resources to make available to individuals and families.

Later in this report I will discuss the themes from the qualitative study in which 98 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 in 2021, during the 19th review period.

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 2022 across all the DARS and DBHDS waiver employment programs which responds to ***CI 14.9.*** 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 2022. The Commonwealth has again not met ***CI 14.8*** because the number of individuals in waiver employment services is not within 10% of the target goal.

Compliance Indicator 14.10 addresses DBHDS' continued demonstration of 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 the unduplicated number of recipients).

DBHDS did not report separately on its progress to meet the requirement of ***CI 14.10*** to increase service authorizations by 3.5% of the DD Waiver population being served in the most integrated settings for integrated day activities. However, it does include a table in its semiannual report that indicates the service authorizations for unique individuals between 9/30/20 and 6/30/22. These service authorizations for Community Coaching (-55); Community Engagement (-83); ISE (-30); and GSE (-1); have all decreased by a total of 169. Workplace Assistance authorizations increased from 49-54. This information is captured in Table 4: Individuals Authorized for Day Services later in this report.

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 2021 and June 2022, the Commonwealth does not appear to be 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. The Commonwealth has again not met the requirements of ***CI 14.10*** as a result of the decreases in these service authorizations.

DBHDS did include recommendations in the most recent Semiannual Employment Report. These include follow up with providers to ensure data accuracy; incorporate Ticket to Work and Ability One data; discuss responsibility to other disability populations; and ensure the right data is being collected and reported.

DBHDS made relevant recommendations in FY19 that have yet to be fully 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. (done)*
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, especially youth graduating from school. I am pleased that the E1AG has also made this recommendation, however DBHDS has not yet undertaken this analysis over the four years since the E1AG initially 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 and ESOs will assist the DBHDS to achieve its overall targets in the next fiscal year.

VI. 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 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 (CE).

I reported in the 19th review period that Virginia has lost ground providing CE and CC services. I recommended and the DBHDS leadership agreed to reestablish the CEAG as a beneficial step to determine and implement plans to address both barriers and performance. The CEAG began meeting in November 2021 and has met regularly since then. Its members include provider, family, advocate, CSB, DBHDS and DMAS representatives. The advisory group set the expectations that it will promote the understanding of the community engagement philosophy; offer training to individuals, families and providers; and promote learning from providers who have successfully offered CE. The members conducted a survey in April 2022 to which they had over 300 responses. DQV reviewed the survey design and made recommendations for future surveys to improve the response rate and gather more meaningful data.

A work plan has been developed based on the survey results and the input of the CEAG members. The work plan addresses four goals to:

1. Improve the understanding and philosophy among stakeholders, providers, and state agencies of Community Life Engagement based on accepted national standards (Four core pillars) and in alignment with best practice.

2. Improve the understanding of services and supports that can lead to community life engagement.

3. Ensure Community Engagement services are being offered and provided to individuals across the state in the most integrated community settings based on the needs of the individual determined through the person-centered planning process.

4. Ensure that there is an increase in meaningful Community Life Engagement for each individual.

Each goal includes strategies, inputs, activities, outputs and initial, intermediate and long-range outcomes. Timelines are not included in the workplan but the goals and strategies which are based on national best practice standards should advance the Commonwealth's commitment to ensure meaningful discussions of community engagement, CE goals, and the development of sufficient provider capacity to offer community engagement and community.

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 6/30/22. This information reflects the number of individuals authorized for each service type.

Table 4: Individuals Authorized for Day Services 6/30/19-6/30/22							
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**
06/30/22	**5087**	**204**	**2039**	**674**	**309**	**54**	**8,367**
Change	**-1,458**	**-79**	**-611**	**-115**	**-243**	**-15**	**-2,521**

In the twelve- month period, 6/30/21 to 6/30/22, there was a further decrease of the number of individuals authorized for all types of day services as noted in Table 4., There is significant decreases in all service authorizations between 6/30/19 and 6/30/22. These reductions equal 22% in Group Day; 28% in Community Coaching; 23% in Community Engagement; 15% in ISE; 44% in GSE; and 22% in Workplace Assistance. The reductions in Group Day do not appear to reflect the Commonwealth's shift to CE and employment as there are reductions in those authorizations as well.

These employment and day support programs had 8,367 individuals authorized as of 6/30/22 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 1,063 individual authorizations between FY19 and FY22. This is a 24% decrease which is significant. Of equal concern is that DBHDS ended service authorizations for individuals who were not able to participate in services during COVID. A significant decrease in service authorizations is not a positive outcome for individuals with IDD. In fact, it is the opposite of the desired outcome the Parties agree to in the SA. Regardless of the reasons this is occurring, individuals who are waiver participants are entitled to and need to have access to these services as was envisioned by the Parties.

The percentage of individuals authorized for CC, CS, GSE and ISE remained 39% of the individuals authorized for some type of day support service in June 2022, similar to the three previous years. While DBHDS produces data that allows for a comparison of individuals 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 particularly because it appears from the three qualitative studies completed by the Expert Reviewer that there is insufficient capacity of CE providers. This conclusion is supported by data included in the Provider Data Summary Report: May 2022 v. July 2021. There are forty-nine providers of Community Coaching, with 8-14 per region. This is noted as a decrease from the previous report. There are 152 Community Engagement providers, with 17-45 per region. This is noted as a decrease in Regions 2, 3, and 4. The Provider Data Summary Report does not include an analysis of need versus capacity. DBHDS notes that some CE providers stopped providing CE during the COVID pandemic. The rates for CC and CE have been increased this fiscal year which is a positive initiative to attract additional providers and retain those still offering these services.

***Conclusion and Recommendations**:* The DBHDS and the CEAG have developed a robust definition of Integrated Day Activities, which it now calls Community Engagement. These services have been approved by CMS and offered to waiver participants since September 2016. There is a total of 8,367 individuals authorized for waiver day services including center-based day services, which reflects a continued decrease since FY2020. 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 2,521 (23%) of individuals authorized for any day service is startling, and the decrease in authorizations for IDA services of 24% is of more concern.

As of June 2022, 2,233 of these individuals are authorized for CE and Community Coaching (CC) compared to 2,933 in June 2019. This is 700 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 98 individuals during this reporting period that there are not enough CE providers in all parts of the Commonwealth. Hopefully, DBHDS' increased rates for CC and CE will be a sufficient enhancement to provider participation and capacity.

DBHDS has started supporting residential providers to 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 be able 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 a 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 CE and CC services. We found many CMs do not demonstrate this understanding when we reviewed the 98 records in the sample for the IDA Qualitative Study. 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 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. It is understandable that there has been some retrenchment of these services that are based on integration and inclusion within communities as people are still reticent to engage in interactive activities while the fear of COVID remains. Hopefully as we have seen more people returning to work, waiver participants will reengage with their communities in the coming year.

During this review period we continue to see a decrease the number of authorizations of community engagement services and community coaching. In addition, it does not appear from the qualitative studies that were conducted since 2019 that CMs are well prepared to discuss CE options with individuals and families, nor may there be a sufficient number of 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 such programs were available nearby and if the benefits were well explained and understood.

There appears to be a need to further educate Case Managers to explain CE to individuals and families and to help them 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. 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 Qualitative Study of Integrated Day Activities. Hopefully the CEAG can assist DBHDS and the CSBs to promote these integrated day options more purposefully.

The Commonwealth does meet the provisions of III.C.7.b.i. because the Commonwealth has set the employment targets and reports regularly on all of the required data.

VII. 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 employs 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 Commonwealth expects that 100% of individuals with I/DD with a case manager will have "employment services and goals developed and discussed at least annually" by 12/30/15, and that 50% of these individuals will have an employment or employment-related goal in the Individual Service Plan (ISP). The Parties have agreed to specific Compliance Indicators in this area. The indicators require that employment discussions are held with 86% of individuals in waiver programs and that employment goals are set for 50% of these same individuals who are age18-64.

DBHDS reports on the status of meeting the requirements of CI , 14.3, 14.5, 14.6, and 14.7 in the Case Management Steering Committee Semiannual Reports (CMSC). I reviewed the reports issued for FY22 Q1 and Q2; and FY22 Q3 and Q4. The process and data verification for these indicators is discussed later in the report.

Employment Discussion with Individuals- DBHDS reports that a total of 10,623 adults' case managers conducted annual ISP meetings or updates between July 1, 2021, and June 30, 2022. However, there are 13,528 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 78% of the total number of adults on one of the HCBS waivers. Of these 10,623 individuals, their case managers checked a box that indicated that a total of 10,460 individuals had discussed integrated, community-based employment during their annual ISP meetings. This indicates that 98% of the individuals who had an ISP meeting conducted discussed employment at some level, compared to 97% as of the previous report. No CSB reported that fewer than 92% of adults who had an ISP meeting in FY22 discussed employment. Our study found a substantial discrepancy, that only 40% of adults (40 of 100) in the sample had a meaningful employment discussion.

A total of 2,742 of the 10,623 individuals as of June 2022 who had ISP meetings have an employment related goal. This results in a statewide average of 26% of individuals who had an annual ISP review in this reporting period who have an employment or an employment-related goal in their ISP which is required by ***CI 14.3*** which required that 50% of all adults (18-64) have goals related to employment. This compares to 27% and 30% in the past two years. Only four of the forty (10%) CSBs (Goochland-Powhatan 50%, Arlington 53%, Eastern Shores 57% and Dickensen 100 %) met or exceeded the target of setting employment goals for at least 50% of adult on the HCBS waivers. ***CI 14.3*** is again not met.

CI 14.7 expects that at least 86% of individuals aged 14-17 who receive waiver services will have a discussion about their interest in employment. The DBHDS has reported on this CI in the Case Management Steering Committee (SCSC) semiannual reports for FY22. Only 31% of the ISPs for this age group showed evidence of an employment discussion of employment, what they are working on at school that supports future employment, and how waiver services can support their readiness for work. ***CI 14.7*** is again not met.

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 a total of 12,396 adults' case managers conducted annual ISP meetings or updates between July 1, 2021, and June 30,2022. However, there are 15,394 individuals on a HCBS waiver who have a CM and should have an annual ISP meeting. This number is greater than the number 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 limited to 18-64-year-old adults. The DBHDS report from the CSBs reflects data from ISP meeting for 80 % of the total number of adults on one of the HCBS waivers. Of these 12,396 individuals, their case managers checked a box that indicated that a total of 11,836 individuals had discussed integrated, community-based employment during their annual ISP meetings. This indicates that 95% of the individuals who had an ISP meeting conducted discussed CE at some level. Our IDA Study again found a substantial discrepancy. Our study identified evidence of meaningful discussions with only 36% of the 100 individuals in the sample.

The number of CSBs reporting these conversations with at least 86% of individuals was thirty-seven. The other three CSBs reported between 78%-85%. 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. In the IDA Qualitative Study of

98 individuals, we found that overall, only 30% had a goal. Of those with an interest in ICI, 66% had a goal. The CQI SCQR review reports that 57% of the individuals had a goal for ICI.

The Parties also agreed to a Compliance Indicator for the percentage of individuals on the waiver who would have a community engagement goal. This CI is set for 86% of all waiver participants to have this type of goal. As reported by the CSBs this expectation has not been realized. The state average for setting CE goals increased to 50% from 38% as reported in the previous two reporting periods. There were two CSBs who set goals for at least 86% of their waiver participants: Arlington and Portsmouth both at 89%. Two other CSBs reported setting CE goals for 82% of waiver participants. It is important to look at the data specific to each of the forty CSBs. The following table, ***Table 6*** provides a breakdown of the percentage of individuals by CSB who have a goal for integrated community inclusion (ICI). This is the broader term DBHDS now uses when discussing integrated day activities.

Table 5: ICI Goals Set by CSBs	
% of CSBs with ICI Goals Set	**Number of CSBs Setting CE Goals**
86% or above	2
80-85%	2
70-79%	7
60-69%	3
50-59%	7
40-49%	10
30-39%	5
20-29%	3
10-19%	0
1-9%	1

This review cannot verify that the Commonwealth has met the benchmark percentages for these CIs. The CSBs report that 95% of individuals had CE discussions and 50% had goals set for CE. However, these percentages are based on only 80% of the ISPs being reported because of the requirements for data completion. While DBHDS does not rely on the SCQR process to determine the percentage of individuals who have a discussion or a goal, DBHDS uses the results of the SCQR to provide a qualitative review of the CSB data and to follow up with the CSBs to improve reporting. We find the SCQR to be a reliable and valid process as we discuss in the IDA Qualitative Study.

We do not find the process the DBHDS is using to determine these CIs to be reliable or valid as is described later in this report. The SCQR process and our review process analyzes ISP documentation to determine if a meaningful discussion has occurred for both employment

and ICI. Both CQI and we have defined criteria for a meaningful discussion which is detailed in the IDA study. In this reporting period DBHDS continues to report the presence of check marks on a checklist in the ISP as sufficient indication of a discussion occurring. There is also extensive evidence from many independent reviews of service provision in Virginia that a checked box without supporting documentation is not a reliable indicator that a particular task has actually been completed.

DBHDS did implement the recommendations that I made in the 19th review period regarding the criteria that demonstrate a meaningful discussion occurs. DBHDS CQI staff added these criteria in December 2021 to its guidelines for reviewers to use when determining if employment and ICI discussions occurs. These criteria could not be added to the ISP forms that the CSBs use until May 2022 because of contractual requirements between the CSBs and the Commonwealth. As a result, this year's review does not reflect these changes in full as implemented by DBHDS.

The Commonwealth reports using its processes including direct reporting from CMs at CSBs that only 26% of all individuals have an employment goal and 50% have an ICI goal. Again, in this period, neither ***CI 14.3*** nor ***14.6*** are met. These percentages make it questionable if discussions as reported by the CSBs truly occurred for 95% and 98% of the individuals for ICI and employment respectively. It seems logical that if there had been discussions that explored interests, available services and addressed individual's and families' questions more individuals would have a goal or at least one that focused on employment or ICI readiness.

The Commonwealth has again not met the requirements for ***CIs 14.02, 14.03, 14.05, 14.06 or 14.07.*** While its CSB reports indicate achievement of the required outcome measures included in ***CI 14.02*** and ***CI 14.05*** there has been no verification of the validity of the data. It is not reflective of all individuals who should have had an ISP but represents approximately 78% of the cohorts for both employment and CE. In addition, the findings of this period's IDA Study completed by the Expert Reviewers identified significant discrepancies with the CSB's self-reported findings.

DBHDS is following up with CSBs who are not meeting the expectations of the CIs. DBHDS sent letters to each CSB in May 2022 to summarize the results of the CSB Performance Reviews. The letters were specific to the performance expectations for Integrated Community Involvement (ICI), as well as three other areas of expectations: WaMS data entry; Regional Support Team referral timeliness; and Support Coordination Quality Review sample completion.

The letters were directed to the CSB Boards for their information and monitoring. This year, DBHDS did not require a corrective action plan in the area of ICI. The performance measure that was reviewed was the number of individuals who have goals for ICI. The applicable compliance indicator expectation is that 86% of individuals receiving case management services will have an ICI goal/outcome in their ISP. The periods included in this review were FY22 Q1 and FY22 Q2. FY22 Q2 is within this review for the twentieth and twenty-first periods. Only three CSBs were at or above the benchmark level of 86%. Six CSBs were in the range of 70-85% compliance in FY22 Q2. Nine CSBs (22.5%) had

improved between FY22 Q1 and Q2; two CSBS (5%) achieved the same level of compliance; and twenty-nine (72.5%) had regressed in their achievement in this area. DBHDS will send letters regarding compliance semiannually. CSBs will be offered technical assistance from DBHDS to determine improvement strategies. If there are two cycles of underperformance, the CSB will be required to submit a performance improvement plan to DBHDS.

The Support Coordination Quality Review

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. These reviews should occur as part of a process to review the data that is submitted by CMs and to determine that all of the expectations that are set for CMs regarding the development of the ISP are met. This was done through its Service Coordinator Quality Review (SCQR) process in which CSB supervisors and DBHDS Quality Improvement staff review 400 and 100 records respectively, that were randomly selected. The 100 records randomly selected by the CQI staff are selected from the 400 that were reviewed by the CM Supervisors. Definitions of what DBHDS expects to see in a record to document if a discussion occurred were developed and shared with CQI reviewers. A process of inter-rater reliability was designed for the reviews conducted by the DBHDS CQI reviewers.

DBHDS reports that it utilizes data from ISPs completed by CSB case managers for compliance reporting for CIs 14.2, 14.3, 14.5 or 14.6. This consultant's 21st period's qualitative review found significant discrepancies with, and could not validate the accuracy of, some of the data reported by the Commonwealth this period. However, it is important for the reader to be aware of the SCQR process and DBHDS' use of its findings. These qualitative findings are critically important to improving the work of the CSBs to hold meaningful discussions and report the data properly. The results of the SCQR will help improve performance and quality over time. We use the same general process as DBHDS to conduct the IDA Qualitative Study.

The SCQR includes questions about employment and CE under the "All Other Questions" section, not related to one of the ten specific Indicators. The SCQR Survey Instrument and Technical Guidance was updated in December 2021 to enhance the criteria and process it uses to determine if the CIs related to employment and ICI discussions and setting goals occur and are properly documented in the ISPs. The guidance for the questions related to these discussions has been clarified. There must be evidence of all the following elements for a meaningful discussion to occur. Previously the SCQR only required the CM to have documented that at least one element on the following list was discussed.

DBHDS has now clarified that for a SCQR reviewer "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 all 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

Another DBHDS question asks: Is there evidence in the record that the CM discussed options for integrated community involvement/CE/CC?

Again, DBHDS specifies that, "To indicate a Yes answer, there must be clear documentation in the ISP Essential Information under "Summarize community engagement conversation and how barriers will be addresses as applicable" that confirms discussion of all 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

In our IDA study following the 19th reporting period, we questioned why the SCQR process allowed for a conclusion of Yes and a finding of Met if evidence is present for only one of the above criteria for either an employment or CE discussion. One of these would rarely, if ever, be sufficient to indicate there was a meaningful conversation. This would certainly not be the case for: satisfaction, barriers or a timeline for future review independent of discussing an individual's interests and providing an explanation of the services and service options. We fully support the change that has been made in the SCQR process as it will lead to more accurate and valid conclusions as to whether a meaningful discussion has occurred.

Later in this report I summarize the findings and conclusions from the employment qualitative study that we undertook using 98 of the 100 records that were part of the DBHDS SCQR monitoring initiative. It is not apparent from this study that meaningful discussions occur at the rate the CSBs report or that there is consistent follow up by the Case Managers and teams to educate individuals and families about employment and address barriers.

There is a lack of evidence in the plans that we reviewed in the IDA Study that meaningful discussions take place at most 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 meaningfully 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 frequently not apparent that CMs discuss the specific employment options offered by DARS and the HCBS waivers. These are consistent with our findings of our study following the 19th review period in 2021.

The Engagement of the SELN - DBHDS established the VA SELN Advisory Group to assist it 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. DBHDS renamed the SELN Advisory Group as the Employment First Advisory Group (E1AG). Its members are appointed for two-year terms. DBHDS expanded the E1AG to include members representing behavioral health. This group includes self-advocates, family members, advocacy organizations, CSB staff, educators, employment providers, and assigned staff from the following state agencies: DBHDS, DMAS, DARS, and VDOE.

This Advisory Group has several sub-committees: membership, training and education, policy, and data. I reviewed the minutes from the bimonthly meetings of the full E1AG. 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 toward meeting the Settlement Agreement requirements for employment. From the information provided, it is apparent that the E1AG and its sub-committees remain active although sub-committees have met less frequently this year in part due to the COVID pandemic.

1.***The operation of the SELN and the opportunity afforded its members to have input into the planning process*** **-**most of the members who I interviewed continue to report that the E1AG is active and has a diverse and effective membership. Members are satisfied with the expansion of the E1AG's mission to address the needs of individuals who have mental health and substance use needs in the Commonwealth. The members welcome the new initiatives that embrace the needs of these diverse populations.

Members report less opportunity for meaningful input. Meetings were held using Zoom for this reporting period although the October meeting was to be a hybrid meeting offering members who can attend in person. Members report the use of Zoom has shortened the meetings. The agendas are more focused on presentations from DBHDS staff. Materials are not shared ahead of time. Members report this limits their ability to provide feedback, ask questions or complete any review and analysis of the documents prior to the meeting. There has been less employment data shared this year limiting the role of the data sub-committee. Members appreciate the structure of the sub-committees for policy, training and data, but ask that these meetings return to in-person so they can advance their work more effectively. The training committee has been the most active this year but has yet to complete its project of developing a resource guide that addresses needs for education and information about employment across the lifespan. The committee's structure is for the full E1AG to meet bimonthly and for both sub-committees to meet during alternate months.

The members continue to ask to have the Employment Services Coordinator coordinate the work of the E1AG and the sub-committees. The lack of such coordination was expressed as a concern last year and has not been satisfactorily resolved.

Some members would like the E1AG's agendas and work to be driven with more input from the committee members with DBHDS responding to requests for data and providing progress reports on implementation of recommendations made by the E1AG. The E1AG members continue to be express concerns expressed that the focus on presentations from DBHDS that do not include sufficient time to review the material which diminishes the involvement of the E1AG as a policy advisory group.

2. ***Review of the Employment Targets***- E1AG members appreciate the continued progress to increase the number of individuals who are employed, both overall and in the waiver programs through December 2019, while acknowledging that the waiver targets are not being met. DBHDS shared the December 2021 Semiannual Employment Report with the E1AG. There remains disappointment that the significant progress towards meeting the targets reflected through 2019 continues to be stalled by significant losses of jobs as a result of COVID. There is some rebounding this year which is welcome. Members reviewed the employment targets based on the December 2021 Semiannual Report and agreed with the DBHDS that the targets needed to be reset as described earlier in this report.

3. ***Review of CSB Targets-*** As was true last year, E1AG meetings have not focused on the review of these targets. Members think that Case Managers will benefit from continued training on employment to fully embrace the principles, intent, and policy direction. In the ISP planning process Case Managers need a greater understanding of their role assisting families and individuals to seriously consider employment as the first and priority option. There continues to be concern expressed that the workload of CMs and the high turnover limits their ability to work effectively with families to meaningfully consider employment for their children with I/DD or to be able to facilitate productive discussions to address barriers to employment. Members are also concerned that CMs are not well trained or prepared to discuss the impact of employment on benefits. Some members are concerned whether CMs can help families whose children have significant disabilities to understand the possibilities of work. Some E1AG members believe that it would be more useful to have families connect more directly to benefit specialists and employment providers to increase interest and confidence in pursuing employment for their children. These concerns have been expressed by committee members in the past as well as during these interviews.

4. Review of the RQC Recommendations- The recommendations of the RQCs are shared with the E1AG. Members report that similar concerns are expressed by the various RQC's and are similar from one reporting period to the next. The members agree with the general concerns and feel the E1AG and DBHDS are working to address the issues of training, capacity, waiver service access, and transportation. This feedback was consistent with last year's interviews. None of the members who were interviewed report being told of any feedback from the RQCs on the employment targets which is a requirement of the SA.

5. Interagency Initiatives- the members of the E1AG who I interviewed continue to be positive about the interagency cooperation between DBHDS and DARS. DARS continues to increase opportunities for Customized Employment. Part of this effort is to address the needs of the MH and SU populations and include Peer Connections and Recovery Support. DARS LTESS program for those individuals in the most severe category of need has been continuously opened since January 2020. Virginia has also been selected as one of seventeen states to receive federal funding from ODEP to help individuals earning less than minimum wage to increase their earnings to minimum wage or a higher amount.

Conclusion and Recommendation: The DBHDS continues to meet the SA requirements to maintain the SELN, has set goals for the CSBs in the performance contracts, but has not fully met the provisions of *III.C.7.b.* as highlighted earlier in this report. The CSBs have not consistently offered employment as the first and priority option or developed and discussed employment service goals annually, a target that was anticipated to be achieved by June 2015. DBHDS has an Employment Services Coordinator.

VIII. 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 FY22 Q2, FY22Q3 and FY22Q4. There were more robust discussions of employment and CE across all five RQCs. RQC members across the Regions had discussions and made recommendations about various aspects of employment. Region 1 focused on meaningful discussions of employment; Region 2 on data collection; Regions 3 and 5 on employment transportation; and Region 4 on improving partnerships with business. A member of the Region 5 RQC who is a Quality Improvement Specialist has joined the E1AG. There is no evidence that all the RQC recommendations were shared with the E1AG during this review period or that the RQCs discussed the employment targets and provided feedback.

The RQCs' meeting minutes reflect that DBHDS consistently made presentations about employment. During this review period, it does not appear that DBHDS has discussed the reductions it made in the employment targets for the waiver with any of the RQCs. However, the RQCs have fulfilled most of their functions related to reviewing employment

data and discussing employment challenges, making recommendations for future actions. While it did not fulfill the specific requirement to review the targets DBHDS was proposing it has done so previously in earlier reporting periods. Maintaining compliance with this provision of the SA will require DBHDS to share the employment targets next year with each RQC and share the Councils' recommendations regarding the targets with the E1AG.

The Commonwealth is responding to the requirement of involving the RQCs because the meetings were held, and employment information was at least presented. Targets are expected to be reviewed on an annual basis and were not reviewed during this reporting period as evidence by the four quarters for which RQC minutes were provided.

Conclusions and Recommendations: DBHDS did meet the provision of III.C.7.c because there appears to have not been a quarterly review of employment data. DBHDS met the spirit of the provisions of III.C.7.d.The RQCs continue to engage in more meaningful discussions about employment data and barriers.

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

Compliance Indicator III.C.7.a: 1.a.-g. *CI14.1* requires all CMs to take online employment training. Virginia met the requirements of this CI in Year 6 (the eighteenth and nineteenth reporting periods). I requested for this reporting period, Year 7, DBHDS confirmed that all new CMs took the online training. DBHDS was able to verify that there are 683 CMs who work in developmental disability services in the CSBs. Of these, 394 took the online training this year. This is 58% of the CMs which is more than the percentage of turnover which was 39% of the workforce this past year. The department did not have a list by name of the 394 CMs who took the online training. Virginia uses this data to affirm that all new CMs took the training. The training continues to include the information required by this compliance indicator.

In conclusion, as it did during the 19th review period, Virginia has again Met the requirements of compliance indicator 14.1 regarding employment and community engagement training for its CMs.

The remaining CIs that address employment and CE expectations of the SA focus 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, in terms of the Commonwealth's ability to meet the performance expectations of the CIs but will be summarized below. All the remaining nine CIs rely on data and therefore need processes and the DBHDS' ability to demonstrate the data is both reliable and valid.

Review and Analysis of the CI Processes and Data Validation

CI 14.2 The Commonwealth will achieve compliance with this provision of the Settlement agreement when: At least 86% of individuals (age 18-64) who are receiving waiver services will have a discussion regarding employment as part of their ISP planning process.

CI 14.3 At least 50% of ISPs of individuals (age 18-64) who are receiving waiver services include goals related to employment.

CI 14.4 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 14.5 At least 86% of individuals (age 18-64) 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 14.6 At least 86% of individuals (age 18-64) who are receiving waiver services will have goals for involvement in their community developed in their annual ISP.

CI 14.7 At least 86% of individuals aged 14-17 who are receiving waiver services will have a discussion about their interest in employment and what type will be working on while at home and in school toward obtaining employment upon graduation, and how their waiver services can support their readiness for work, included in their ISP.

Facts: DBHDS submitted one process document to address the seven CIs listed above. This process depends on the reliable and valid data submitted from CSB data submissions, Case Management Quality Reviews, Office of Licensing Citations, Quality Service Reviews, DMAS Quality Management Reviews and WaMS. DBHDS reports that this process was updated June of 2022. DBHDS reported on the outcomes related to the progress meeting these CIs for FY 22Q1 through FY22Q4 in the Case Management Steering Committee (CMSC) and Semiannual Employment Reports.

DBHDS provides a summary of the purpose of this process which is as follows: the CMSC, a subcommittee of the DBHDS Quality Improvement Committee (QIC), is responsible for monitoring case management performance across responsible entities. This includes identifying and addressing risks of harm, ensuring the sufficiency, accessibility and quality of services to meet individuals' needs in integrated settings and evaluating data to identify and respond to trends to ensure continuous quality improvement. This process defines the CMSC procedures for reviewing, remediating and reporting on case management performance in key areas monitored by the Committee. It outlines the data used by the CMSC, as well as actions and activities designed to improve case management performance at the local and system levels.

Attestations: DBHDS submitted attestation forms for *CIs 14.2,14.3, 14.4, 14.5, 14.6, and 14.7* on September 2, 2022.

The Attestations did not include the creation of a sample data set, for any CI, in order to perform a data set validation. No defects were identified. The CIO concluded that the data is representative of the data to be collected and the processes that were followed were thorough and detailed and therefore reliable and valid for all the above CIs.

Analysis: The review of this process included a review of the Process Document, an interview with the data analyst to explain the spreadsheet and verification process for determining the validity and reliability of these processes to address these CIs. We found major weaknesses were found in the process used to collect data for these compliance indicators. Both ISP versions 3.1 and 3.2 were used in this reporting period. The process relied on the CM checking boxes to validate the discussions. The spreadsheet used to determine the validity and reliability of these answers, does not allow for a valid check of the supporting information entered by the case manager. In addition, there has been no interrater reliability check prior to the data being entered into the WaMS system, which is where this information is extracted, or after it is entered into the spreadsheet. While the ISP version 3.2 is an improvement from 3.1, this newer version is still unable to provide sufficient, reliable and valid data for this verification purpose.

During the interview the staff reviewed the new ISP version 3.3, which will be used as a source of data during future reporting periods, and how data relating to these specific questions will be validated using formulas in the spreadsheet. It appears that the data analyst and the expert reviewer will be able separately conduct a validation study once a significant sample has been loaded. Such a sample was not available for this study. I was informed that version 3.3 was implemented on May 17,2022.

The Process document submitted by DBHDS applies to twenty-two CIs in total. The six CIs named above are included in the twenty-two. The Introduction section of the Process Document identifies the CMSC as responsible for reviewing the data sets from all the entities mentioned in the data reports used. Yet no inter-rater reliability process was mentioned as being used by CMSC to validate the submitted samples. The process also defines the CMSC as having the responsibility, via its procedures, for reviewing, remediating and reporting on case management performance in key areas monitored by the committee. The process attempts to outline that the data used by CMSC are designed to improve case management performance at the local and system levels. Yet there is a weakness inherent in the process that may create several false positives in this area, consequently allowing for a highly inflated number for compliance reporting.

Conclusion: Given those weaknesses, mentioned in the analysis, I cannot find the process as described produces valid or reliable data for compliance reporting. The Attestations did not include the creation of sample data sets and therefore our review could not complete the necessary spot-check verifications.

CI 14.8 New Waiver Targets established with the Employment First Advisory Group: Compliance with the Settlement Agreement is attained when the Commonwealth is within 10% of the targets. New Waiver targets established with the Employment First Advisory

Group: FY20 is 936 individuals in ISE and 550 individuals in GSE for a total of 1486 in supported employment.

CI 14.9 The Commonwealth has established an overall target of employment of 25% of the combined total of adults' aged 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.

Facts: There is one Process Document for these three CIs. The data for the *CIs 14.8, 14.9 and 14.10* are pulled semiannually. The data sources are the data surveys sent to employment providers, which is the Final Employment Analysis, and DARS employment data for the participation of individuals with DD in DARS funded employment support programs. The Data Surveys capture the following metrics, which provide a snapshot assessment of DBHDS' progress toward meeting compliance indicators. These are: Type of Work Setting by Funding Source; Type of Work Setting by Developmental Services DD Regions; Type of Work setting by Diagnosis; Type of Work Setting by Diagnosis and Region; Age by Service Type; Hours Worked; Length of Time Employed; and Wages. The Control Point is clear, concise and monitored throughout the process. Weaknesses in four process steps are acknowledged and a manual work around has been established with a permanent fix to those weaknesses set to take place on 10/28/22. There are two necessary data cleaning steps in the process to ensure only accurately completed data sets are used in the calculations. This process was created on February 1, 2022.

Attestations: The Commonwealth has not attested to the reliability and validity of the data reported for these CIs. No attestations were received from the Commonwealth by the date this report was submitted to the Independent Reviewer. I requested these be submitted on 10/16/22.

Analysis: The review of the Commonwealth's process included a review of the Employment Reporting Analysis Process, the Employment Reporting Analysis Workbook v4. xlsx and the Employment Data Survey Training Guide as well as an interview with the data analyst who developed and is responsible for the implementation of the survey process and tabulations. Given the attention to detail in the process and the fact the process eliminates any incorrect or incomplete survey data for the sample creates considerable reliability and validity to the process. In addition, any data that is eliminated due to errors or incompleteness must be corrected prior to the next reporting period and is then included in that reporting period. Thus, adding more numbers to that sample size and possibly generating a more statistically significant sample. Additionally, and more importantly the process is set up so that at any time after the sample is completed the Data Analyst or an independent reviewer can complete a validation study quite efficiently.

Conclusion: The process is well thought out with appropriate work arounds for all previously identified and inherent weaknesses and DBHDS has established written data cleaning points where necessary. These factors suggest that once I conduct a validation

study, a determination is likely that the process produces valid and reliable data for compliance reporting.

X. Summary

As noted in the previous section DBHDS has not yet provided reliable and valid data regarding CIs 14.2-14.7. The following is a summary of the performance by the Commonwealth for each CI which has been addressed in greater detail earlier in this report.

CI 14.2 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. The CSBs report that discussions are held with 98% of the individuals who had ISP meetings between June 2021 and June 2022. However, this is only determined by a CM checking a box that a discussion was held. This reviewer's study of the available documentation found that only 40% of individuals included a meaningful discussion. Additionally, ISPs were only conducted for 78% of the waiver participants ages 18-64. ***CI 14.02 is not met.***

CI 14.3 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. The CSBs report that employment goals were set for 26% of the individuals who had ISP meetings between June 2021 and June 2022. The percentage is far below the expectation of 50% and the CSB methodology for collecting this data has not been verified. ***CI14.03 is not met.***

CI 14.4 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. DBHDS reports that only 72% of individuals who had employment services authorized in the reporting period had a provider and started services within sixty days. ***CI 14.04 is not met.***

CI 14.5 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. The CSBs report that discussions are held with 95% of the individuals who had ISP meetings between June 2021 and June 202 2. However, this is only determined by a CM checking a box that a discussion was held. This reviewer's study of the available documentation found that only 36% of individuals included a meaningful discussion. Additionally, ISPs were only conducted for 80% of the waiver participants age 18 or older. ***CI 14.5 is not met.***

CI 14.6 At least 86% of individuals who are receiving waiver services will have goals for involvement in their community developed in their annual ISP. The CSBs report that CE goals were set for 50% of the individuals who had ISP meetings between June 2021 and

June 2022 which does not meet the CI requirement of 86%. This reviewer's study of the available documentation found that only 29% of ISPs included CE goals. ***CI 14.6 is not met.***

CI 14.7 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. DBHDS reports that these discussions occurred for only 31% of the adolescents who had ISPs in FY22. ***CI 14.7 is not met.***

CI 14.8 New Waiver Targets established with the Employment First Advisory Group: Compliance with the Settlement Agreement is attained when the Commonwealth is within 10% of the targets. New waiver target established with the Employment First Advisory Group for FY22 is 661 individuals in ISE and 550 individuals in GSE for a total of 1211 in supported employment. There was a total of 764 waiver participants employed in FY22: 530 in ISE and 234 in GSE. ***CI 14.8 is not met.***

CI 14.9 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.
Overall, the Commonwealth reported that 21% of the individuals on the waivers and the waiver wait lists were employed in FY22. ***CI 14.9 are not met.***

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 of recipients).
The Commonwealth reported this information in its Semiannual Employment Report. Integrated Day Services include CC, CE, ISE, GSE and WA. The changes in the number of individuals authorized is displayed in ***Table 4*** in this report. There were significant decreases in service authorizations. ***CI 14.10 is not met.***

DBHDS's previous trend to increase employment and its efforts to implement community engagement continue to be stymied by the COVID pandemic during this reporting period. Fortunately, after two years of declining numbers of individuals employed, there is an increase of 660 individuals employed as of June 2022, of whom sixty-one are waiver participants. However, the targets were not met and to meet them in FY23 will take an increase of 588 individuals employed, including an increase of 172 in ISE.

The percentage of meeting the Commonwealth's overall target for employment increased from 19% to 21%, compared to the expectation that 25% of all individuals on the waivers or the waiting lists will be employed. However, service authorizations for CE decreased during this reporting period. It is also concerning that this decrease appears to be due to insufficient provider capacity to offer CE as a service in all parts of Virginia.

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. They have, however, established a process that may well result in reliable and valid data for compliance reporting in the next reporting period.

The stakeholders who are part of the E1AG remain interested and positive about the Commonwealth's progress and achievements. The E1AG continues to want greater opportunity for input into the employment initiative of the Commonwealth. DBHDS' Employment Services Coordinator should 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.

The documentation provided did not indicate that DBHDS has discussed with any of the five Regional Quality Councils, the reductions it made in the employment targets for waiver recipients as required by provision III.C.7.d.

The Commonwealth's ability to meet the requirements of many of the CIs is reliant on the ISP teams whose work is coordinated by Case Managers. DBHDs and the CSBs need to prioritize training, supervision and direction of these staff if Virginia is to properly implement and achieve the CIs related to discussions and goal setting.

Integrated Day Activities Including Supported Employment Study
21st Review Period

Introduction and Study Methodology

At the request of the Independent Reviewer, a record review of employment and community engagement (CE) and now referred to as Integrated Community Inclusion (ICI) by DBHDS, 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 individual 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 Community Quality Improvement (CQI) staff randomly select 100 records for its data review and verification of Service Coordinator Quality Reviews (SCQR) of 400 records reviewed by CSB supervisors. We reviewed 98 of the same records that were reviewed by the DBHDS CQI staff. The records for two individuals in the CQI look behind review were not shared with us.

The study included a review of the written plans and any other documentation related to employment and ICI discussions during the face-to-face ISP meetings. DBHDS shared ISPs; Provider Part V sections detailing service implementation plans; the Case Manager (CM) quarterly reviews of each ISP; the On-Site Visit Tool (OSVT) summaries, and the CM progress notes.

One hundred adults were selected as the sample for this review of employment and CE, the two primary waiver-funded services in Virginia that comprise integrated day activities. The sample included all forty CSBs and 100 of the individuals whose ISP annual meetings were convened in the year prior to January 2022. DBHDS provided documents for 98 of the 100 individuals in the CQI sample. Progress notes were shared documenting the interactions of the CM with the individual, family and team members between January 2021 and December 2022. Each CSB had 2-4 individuals in the sample CQI staff reviewed and we were supplied. Individuals were affiliated with the following regions:

- Region 1- 23
- Region 2-13
- Region 3-23
- Region 4-19
- Region 5-22

The reviewers studied all the documents to determine:

- 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 or employment readiness goal/outcome for the individual?
- If the individual or AR was not interested in employment at this time 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 (now referred to as ICI) 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 outcome for the individual?
- If the individual or AR was not interested in community engagement at this time 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 additional questions. The additional questions include eighteen questions that address employment and community engagement. The process has increased the questions about these topics from seven to eighteen. The questions now have greater specificity and reflect findings and recommendations we made in the IDA study report from the 19th review period and the CQI staff determined to be necessary to determine if meaningful discussions occurred.

For a reviewer to determine that a meaningful discussion regarding employment or ICI occurred there must be evidence of the following elements:

1. Employment and CI interests
2. Available employment and CI options
3. Timeline for reviewing options in the future, at least annually
4. Any further actions related to employment and CI
5. Barriers related to pursing either employment or CI
6. Addressing barriers, as applicable
7. Satisfaction or dissatisfaction with current employment or CE program, if applicable

The DBHDS SCQR Survey Instrument and Technical Guide Review Service Guidance dated December 29, 2021, states: "To indicate Yes, there must be clear documentation in the ISP Essential Information section that confirms discussion of **each** topic. "(*Highlighting from the guidance.)*

DBHDS has introduced a new version of the ISP which is 3.2. The WaMS ISP version 3.2 has incorporated all these elements into the Essential Information section, using a checklist format. CQI expects the reviewers to use the data in this section when reviewing ISPs that use version 3.2. We found that not all ISPs for the 98 individuals we reviewed were using 3.2 yet. CQI instructs their reviewers to locate actual evidence that the topics were discussed. There is room provided in the ISP 3.2 for the CM to write a narrative summary. We followed the same process for our review.

The SCQR then goes on to include questions about developing an employment outcome/goal (Q43) and whether there was further education to discuss the benefits of employment and to address barriers (Q45). The instructions indicate Q43 is to be answered if the reviewer answered Q40 as Yes. Question 45 is answered if the answer to Q43 is rated as N/A because the individual is not interested in employment at the time. There are similar questions and technical guidance for the questions that pertain to ICI: Q47, Q50 and Q52. Under both employment and ICI, the reviewer is instructed to identify if the evidence was found in the ISP Essential Information section, or other documentation such as the ISP Part V or progress notes.

We reviewed the SCQR questions and review guidelines. We also listened to the video that was used to instruct the reviewers as to what evidence was needed to answer these questions.

When we review the records, we determine the CM had met the requirement to have a discussion about either employment or ICI if there is any evidence of those discussions in either 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 CI, DBHDS expects 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 using 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 to better promote integrated day activities.

In order to make these determinations we considered the following issues when reviewing information in the ISP and related documents:

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 and community engagement that the individual is experiencing?
5. Did the discussions include an explanation of the employment and CE/CC 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 outcome created?

9. Does the outcome reflect the employment discussion (strengths, preferences, needs and barriers)?
10. Is the outcome measurable?
11. Does the plan include outcomes 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 and with the specific Compliance Indicators once they were agreed to by the Parties. These criteria reflect the expectations of DBHDS as articulated in the Employment and Community Engagement Training for CMs. They are incorporated in the seven elements established by the SCQR.

Medical and Behavioral Concerns

Pursuant to the Commonwealth's Employment First policy and its Employment Plan, DBHDS is committed to providing supports for 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. There are 98 individuals in the sample for this study. Of these individuals, eight have medical conditions that the team will need to address. Ten have behavioral concerns that may be a barrier to employment or community inclusion. Only three individuals of the eight with medical issues have such a significant health concern that 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; the ongoing use of crisis services; and updates in the progress notes about medical condition or behavior status.

DBHDS expects teams will work to address individuals' medical and behavioral concerns if these present barriers to employment and community engagement. There was evidence in the records reviewed that teams were addressing the behavior for the ten individuals. The majority of these individuals had a Behavior Support Professional (BSP) and/or a behavioral plan. In a few cases the outcomes for the residential provider to achieve addressed these behaviors.

Findings

ISP document review - DBHDS provided the ISPs for the individuals and included the Part V section completed by the CMs and providers. The section of the ISP that addresses employment and ICI is comprised of check off boxes for each service related to the discussion by the team including the individual's interest; whether the person is deciding to retire; a listing of barriers; and whether there is a plan to address the barriers. The DBHDS expects the team to provide further education to the individual and family about employment and ICI if they are not interested in these services at the time of the ISP meeting. 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 plan to provide further education and information about employment or ICI for individuals who were not interested at the time of the meeting. However, this was rarely completed. The new 3.2 version of the ISP now lists all the elements the CM and team are expected to address regarding employment and ICI. There is a notation to summarize what was discussed but this was not routinely completed by the CM.

The Section V of the ISPs that were shared were the Part Vs completed by the CE, Supported Employment (SE) or Group Day provider, as well as the residential provider. We also reviewed some for personal care services. Overall, this study found that the outcome statements in the Section Vs continue to be weak, very general and for the most part reflect basic rights and life expectations. For example, few of the outcomes/goals include measurable objectives 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, when goals are not measurable, progress 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 the last two qualitative studies conducted in the seventeenth and nineteenth reporting periods. Once again there are some notable exceptions. CSBs should use model ISPs and Part Vs as part of the follow up training for CMs to compliment what is offered by DBHDS. Quarterly progress reports rarely include any data to verify that actual progress is being made to achieve outcomes. Instead, the note is a statement that reflect what activities were going on in the home or program at the time of the CM's visit, and a summary of medical issues. There are usually notations if CMs are assisting families to get supplies, addressing insurance issues, or arranging for different providers.

Employment Discussions and Goal Setting

Table 1 below summarizes by region 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 Discuss	**Interest**	**Plan to Educ**	**Plan Implem**	**Goals Set**	**Identified Barriers**	**Addressed Barriers**	**Med Complex**	**Behav Complex**
REGION 1 WESTERN									
WR1	NO	NO	NO	NO	NA	YES	NO	NO	NO
WR2	NO	NO	NO	NO	NA	YES	YES	NO	YES
WR3	NO	YES	NA	NA	NO	NONE	NA	NO	NO
WR4 (1)	NO	NO	NO	NO	NO	NO	NO	CND	CND
WR5	YES	YES	NA	NA	YES	YES	YES	NO	YES
WR6	NO	NO	NO	NO	NA	YES	YES	NO	YES
WR7	NO	NO	NO	NO	NA	YES	YES	NO	NO
WR8	NO	NO	NO	NO	NA	YES	NO	YES	NO
WR9	YES	YES	NA	NA	NO	NONE	NA	NO	NO
WR10	YES	YES	NA	NA	NO	NONE	NA	NO	NO
WR11	YES	YES	NA	NA	YES	NONE	NA	NO	NO
WR12	NO	YES	NA	NA	NO	NONE	NA	NO	NO
WR13	NO	YES	NA	NA	NO	NONE	NA	NO	NO
WR14	YES	YES	NA	NA	NO	NONE	NA	NO	NO
WR15	NO	YES	NA	NA	NO	NONE	NA	NO	NO
WR16	YES	YES	NA	NA	YES	YES	YES	NO	NO
WR17*	YES	NO	NO	NO	NA	YES	YES	YES	YES
WR18	NO	NO	NO	NO	NA	YES	YES	NO	YES
WR19	NO	NO	NO	NO	NA	YES	NO	NO	NO
WR20	YES	YES	NA	NA	YES	NONE	NA	NO	NO
WR21*	YES	NO	NO	NO	NA	YES	YES	NO	NO
WR22	YES	YES	NA	NA	YES	YES	YES	NO	YES
WR23	NO	NO	NO	NO	NA	NONE	NA	NO	NO
REGION COMPL. %	10 of 23 = 43%	12 of 23 = 52%	0 of 11 = 0%	0 of 11 = 0%	5 of 11 = 45%	22 of 23 =96%	9 of 13 = 69%	2	6

(1)– Records that document that these actions were properly implemented were not provided (IX.C.)

	Employ Discuss	Interest	Plan to Educ	Plan Implem	Goals Set	Identified Barriers	Addressed Barriers	Med Complex	Behav Complex
REGION 2 NORTHERN									
NR1	NO	NO	NO	NO	NA	NONE	NA	NO	NO
NR2	NO	NO	NO	NO	NA	YES	NO	NO	NO
NR3	NO	YES	NA	NA	NO	YES	YES	NO	YES
NR4	YES	YES	NA	NA	YES	NONE	NA	YES	NO
NR5***	YES	NO	NA	NA	NA	YES	YES	YES	NO
NR6**	YES	NO	NA	NA	NA	NONE	NA	NO	NO
NR7***	YES	NO	NA	NA	NA	YES	YES	YES	NO
NR8	NO	NO	NO	NO	NA	NONE	NA	NO	NO
NR9	YES	YES	NA	NA	NO	YES	NO	NO	NO
NR10	YES	YES	NA	NA	YES	YES	YES	NO	NO
NR11	YES	YES	NA	NA	YES	NONE	NA	NO	NO
NR12	NO	YES	NA	NA	NO	YES	YES	NO	NO
NR13	NO	YES	NA	NA	YES	NONE	NA	NO	NO
REGION COMPL. %	7 of 13 = 54%	7 of 13 = 54%	0 of 3 = 0%	0 of 3 = 0%	4 of 7 = 57%	13 of 13 =100%	5 of 7 = 71%	3	1

	Employ Discuss	Interest	Plan to Educ	Plan Implem	Goals Set	Identified Barriers	Addressed Barriers	Med Complex	Behav Complex
REGION 3 SOUTHWEST									
SW1	NO	YES	NA	NA	NO	YES	YES	NO	NO
SW2	YES	YES	NA	NA	NO	NONE	NA	NO	NO
SW3**	YES	NO	NA	NA	NA	NONE	NA	NO	NO
SW4**	YES	NO	NA	NA	NA	NONE	NA	YES	NO
SW5	YES	YES	NA	NA	YES	NONE	NA	NO	NO
SW6	NO	NO	NO	NO	NA	YES	NO	NO	NO
SW7	NO	YES	NA	NA	YES	YES	YES	NO	YES
SW8	YES	YES	NA	NA	YES	YES	YES	NO	NO
SW9	YES	NO	NO	NO	NA	YES	NO	NO	NO
SW10	NO	NO	NO	NO	NA	YES	YES	NO	NO
SW11	NO	NO	NO	NO	NA	YES	NO	NO	NO
SW12	NO	NO	NO	NO	NA	YES	YES	NO	NO
SW13	NO	NO	NO	NO	NA	NONE	NA	NO	NO
SW14 (1)	NO	NO	NO	NO	NA	NONE	NA	NO	NO
SW15	NO	NO	NO	NO	NA	YES	NO	NO	NO
SW16	YES	NO	YES	NO	NA	YES	YES	NO	NO
SW17**	YES	NO	NA	NA	NA	NONE	NA	NO	YES
SW18***	YES	NO	NA	NA	NA	YES	YES	YES	NO
SW19	NO	YES	NA	NA	NO	YES	NO	NO	NO
SW20	YES	YES	NA	NA	YES	YES	YES	NO	NO
SW21	NO	NO	NO	NO	NA	YES	NO	NO	NO
SW22	NO	NO	NO	NO	NA	YES	NO	NO	NO
SW23	NO	NO	NO	NO	NA	NONE	NA	NO	NO
REGION COMPL. %	10 of 23 = 43%	7 of 23 = 30%	1 of 12 = 8%	0 of 12 = 0%	4 of 7 = 57%	23 of 23 =100%	8 of 15 = 53%	2	2

	Employ Discuss	Interest	Plan to Educ	Plan Implem	Goals Set	Identified Barriers	Addressed Barriers	Med Complex	Behav Complex
REGION 4 CENTRAL									
CR1	YES	YES	NA	NA	YES	NONE	NA	NO	NO
CR2	NO	NO	NO	NO	NA	YES	NO	NO	NO
CR3	NO	NO	NO	NO	NA	NONE	NA	NO	NO
CR4	YES	YES	NA	NA	YES	NONE	NA	NO	NO
CR5	YES	YES	NA	NA	YES	YES	YES	NO	NO
CR6	NO	NO	NO	NO	NA	YES	NO	NO	NO
CR7	NO	NO	NO	NO	NA	NONE	NA	NO	NO
CR8	NO	NO	NO	NO	NA	YES	NO	NO	NO
CR9	NO	NO	NO	NO	NA	YES	NO	NO	NO
CR10	NO	NO	YES	NO	NA	YES	NO	NO	NO
CR11	NO	NO	NO	NO	NA	NONE	NA	NO	NO
CR12	YES	YES	NA	NA	YES	NONE	NA	NO	NO
CR13	NO	NO	NO	NO	NA	YES	NO	NO	NO
CR14	NO	NO	NO	NO	NA	YES	NO	NO	NO
CR15	YES	YES	NA	NA	YES	NONE	NA	NO	NO
CR16	NO	NO	NO	NO	NA	NONE	NA	NO	NO
CR17	NO	NO	NO	NO	NA	YES	YES	NO	NO
CR18	YES	YES	NA	NA	YES	YES	YES	NO	NO
CR19	YES	YES	NA	NA	YES	NONE	NA	NO	NO
REGION COMPL. %	7 of 19 = 37%	7 of 19 = 35%	1 of 13 = 8%	0 of 13 = 8%	7 of 7 = 100%	19 of 19 = 100%	3 of 10 = 30%	0	0

	Employ Discuss	Interest	Plan to Educ	Plan Implem	Goals Set	Identified Barriers	Addressed Barriers	Med Complex	Behav Complex
REGION 5 EASTERN									
ER1	NO	NO	NO	NO	NA	YES	NO	NO	NO
ER2	NO	NO	NO	NO	NA	NONE	NA	NO	NO
ER3	NO	NO	NO	NO	NA	YES	NO	NO	NO
ER4	NO	NO	NO	NO	NA	YES	YES	NO	NO
ER5 (1)	NO	NO	NO	NO	NO	NO	NO	CND	CND
ER6	NO	NO	NO	NO	NA	YES	NO	NO	NO
ER7	YES	YES	NA	NA	YES	NONE	NA	NO	NO
ER8	NO	NO	NO	NO	NA	NONE	NA	NO	NO
ER9**	NO	NO	NA	NA	NA	YES	YES	YES	NO
ER10**	NO	NO	NA	NA	NA	YES	YES	NO	NO
ER11*	NO	NO	NO	NO	NA	NONE	NO	NO	NO
ER12	NO	NO	NO	NO	NA	NONE	NA	NO	NO
ER13**	NO	NO	NA	NA	NA	YES	YES	NO	NO
ER14	YES	YES	NA	NA	YES	YES	YES	NO	NO
ER15*	NO	NO	NO	NO	NA	NONE	NA	NO	NO
ER16*	NO	NO	NO	NO	NA	YES	NO	NO	NO
ER17	YES	YES	NA	NA	YES	YES	YES	NO	YES
ER18	YES	YES	NA	NA	YES	NONE	NA	NO	NO
ER19*	YES	NO	YES	YES	NA	YES	YES	NO	YES
ER20**	YES	NO	NA	NA	NA	YES	YES	NO	NO
ER21	NO	NO	NO	NO	NA	NONE	NA	NO	NO
ER22*	NO	NO	NO	NO	NA	YES	NO	NO	NO
REGION COMPL. %	6 of 22 = 27%	4 of 22 = 18%	1 of 14 = 7%	1 of 14 = 7%	4 of 5 = 80%	21 of 22 95%	8 of 15 = 53%	1	1

(1) – Records that document that these actions were properly implemented were not provided (IX.C.)

TOTAL COMPL %	40/100 40%	37/100 37%	3/54 5%	2/54 4%	24/37 65%	98/100 100%	33/60 55%	8	10

KEY

* AR does not want employment

** Retired

*** Unable to work b/c significant medical issues

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.

Again, in its most recent Semiannual Employment Report (June 2022) and based on data submitted by CSBs, DBHDS reported that employment discussions occurred for 98% of all individuals during FY22 for whom an ISP was held. During this twelve-month period, ISPs were in the correct status for data reporting for 78% of the 13,528 waiver participants who were between the ages of 18-64. In contrast, our study found that sufficient discussions were held for only 40% of the sample overall of 100 individuals selected for this Period's study and for only 72% of the individuals in the IDA Study completed in 2021. The percentage of individuals with whom discussions were held across the five Regions in the study ranged from 27%-54%. Region 5 achieved 27% and Region 1 achieved 54%.

The FY 22 SCQRs considered whether seven elements were included to determine if a discussion occurred. The instructions in the SCQR technical guides indicated that every one of the seven elements must be present for there to be sufficient evidence a discussion occurred. DBHDS's CQI has not completed its FY 22 Report with its findings regarding whether discussions occurred that included the data for all seven elements. It is noted in the data summary from the most recently available CQI Report regarding FY 21 that the positive ratings completed by the CSB CM Supervisors were higher, sometimes significantly higher than the ratings made by the DBHDS CQI staff. **The SCQR for FY22 relied on ISPs completed in calendar year 2021 and the SCQR for FY21 relied on ISPs completed in calendar year 2020.**

Almost all the ISPs included in this review included a checked box indicating that the CMs had employment discussions that included at least the seven required elements. 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. In this 21st period study, we confirmed an employment discussion occurred if there was any documentation of the seven elements being discussed in the ISP, Case Managers' Quarterly Reviews or their progress notes that explained or summarized an actual discussion. We found that only 40% had evidence of such discussions whereas the CSBs reported that 98% had such conversations. This discrepancy again shows, as have previous studies, that self-reported checked boxes alone do not reliably verify that a required action has in fact occurred.

We report in **Table 1** whether the individual has expressed an interest in employment. We expect this interest will be supported with an employment outcome. We continue to find that very few teams actually discuss what areas of interest an individual has related to work. Sometimes we found areas of interest in the Important To section of the ISP. These areas were rarely discussed or addressed as the team discussed employment.

Setting an Employment Goal- The Parties have agreed to a Compliance Indicator (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 documented in their ISPs. -Using the agreed upon methodology which does not subtract the individuals who do not express an interest in or have conditions that preclude employment, the percentage of individuals with an employment goal included in their ISPs is only 26% in DBHDS's semiannual employment report dated June 2022, as reported by the CSBs. For this study, the percentage of individuals found with an employment outcome in their ISPs is 24% of the sample.

We present more detailed data regarding the employment goal in ***Table 1*****.** We consider whether employment goals were developed for those individuals who expressed an interest in employment in the hope that the teams will support these interests and offer supports and a path to employment through goals and related activities. Thirty-two of the ninety-eight individuals expressed an interest in employment. Of these individuals 65% (24) had an employment outcome in their ISPs. The percentage ranged from 45% in Region 1 to 100% in Region 4. It is particularly troubling that teams are not developing outcomes and supporting at least all individuals who express a current interest in employment. While the overall finding is concerning, the

discrepancies between Regions is important to note because Region 4 set outcomes for 100% of the individuals who expressed an interest in employment who are supported by their CSBs.

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 noted eight families who have strong objections to either employment and/or ICE. (These individuals are noted in the Tables with one asterisk.) Of these eight families, four had children who had significant medical or physical conditions that would preclude employment. Of the individuals who were not interested, nine had chosen to retire and six have medical or physical conditions that may preclude work.

Overall, only 37% (37) of the individuals expressed an interest in employment and 63% (63) expressed that they did not have interest at this time. This is an increase over the data in these reviewers' 2021 IDA Study which found 26% (26) of the individuals in the sample 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. Overall, eleven individuals had retired and three have significant health and/or physical issues that preclude them from working.

Of the remaining individuals who were not interested in employment, only 5% (3 of 55) individuals have a plan to further educate them about employment, compared to 18% who had a plan in 2021. Upon further review of the records, CMs had only implemented the plans to educate individuals and families for two of these three individuals who were not interested. We did not consider a plan implemented if the only way the CM followed up was to ask the family if they were interested about employment at the next annual ISP meeting and if there was nothing specifically identified to help that family or individual become more knowledgeable of employment options.

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 2021. Each individual either had barriers listed or the team identified there were no barriers. It is of interest that the employment section, unlike the ICI section does not include behavioral or medical issues as barriers. It is more apparent from reading the ISPs in the sample that these issues can present significant barriers to employment.

While the CMs do an excellent job identifying barriers, evidence that barriers are being addressed was found for 55% of the remaining individuals in the sample, a significant increase compared to 40% in last year's sample. Regions range from 30% in Region 4 to 71% in Region 2 for appropriately addressing barriers.

It is critical that ISP teams become proficient in developing specific strategies to address and overcome barriers if more individuals are going to build confidence and become interested in pursuing paths to employment. 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 address 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 the findings for the Community Inclusion/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									
	CI Discuss	**Interest**	**Plan to Educ**	**Plan Implem**	**Goals Set**	**Identified Barriers**	**Addressed Barriers**	**Med Complex**	**Behav Complex**
REGION 1 WESTERN									
WR1	NO	NO	NO	NO	NA	YES	NO	NO	NO
WR2	NO	NO	NO	NO	NA	YES	YES	NO	YES
WR3	NO	YES	NA	NA	NO	NONE	NA	NO	NO
WR4 (1)	NO	NO	NO	NO	NO	NO	NO	CND	CND
WR5	YES	YES	NA	NA	YES	YES	YES	NO	YES
WR6	NO	NO	NO	NO	NA	YES	YES	NO	YES
WR7	NO	NO	NO	NO	NA	YES	YES	NO	NO
WR8	NO	NO	NO	NO	NA	YES	NO	YES	NO
WR9	YES	YES	NA	NA	NO	NONE	NA	NO	NO
WR10	YES	YES	NA	NA	NO	NONE	NA	NO	NO
WR11	YES	YES	NA	NA	YES	NONE	NA	NO	NO
WR12	NO	YES	NA	NA	NO	NONE	NA	NO	NO
WR13	NO	YES	NA	NA	NO	NONE	NA	NO	NO
WR14	YES	YES	NA	NA	NO	NONE	NA	NO	NO
WR15	NO	YES	NA	NA	NO	NONE	NA	NO	NO
WR16	YES	YES	NA	NA	YES	YES	YES	NO	NO
WR17*	YES	NO	NO	NO	NA	YES	YES	YES	YES
WR18	NO	NO	NO	NO	NA	YES	YES	NO	YES
WR19	NO	NO	NO	NO	NA	YES	NO	NO	NO
WR20	YES	YES	NA	NA	YES	NONE	NA	NO	NO
WR21*	YES	NO	NO	NO	NA	YES	YES	NO	NO
WR22	YES	YES	NA	NA	YES	YES	YES	NO	YES
WR23	NO	NO	NO	NO	NA	NONE	NA	NO	NO
REGION COMPL %	10 of 23 = 43%	12 of 23 = 52%	0 of 11 = 0%	0 of 11 = 0%	5 of 13 = 45%	22 of 23 = 96%	9 of 13 = 69%	2	6

WR4 (1) – Records that document that these actions were properly implemented were not provided IX.C.)

	CI Discuss	Interest	Plan to Educ	Plan Implem	Goals Set	Identified Barriers	Addressed Barriers	Med Complex	Behav Complex
REGION 2 NORTHERN									
NR 1	NO	NO	NO	NO	NA	NONE	NA	NO	NO
NR2	NO	NO	NO	NO	NA	NONE	NA	NO	NO
NR3	NO	NO	NO	NO	NA	NONE	NA	NO	YES
NR4	YES	YES	NA	NA	YES	NONE	NA	YES	NO
NR5	NO	NO	NO	NO	NA	YES	NO	YES	NO
NR6	NO	NO	NO	NO	NA	NONE	NA	NO	NO
NR7***	YES	NO	NA	NA	NA	YES	YES	YES	NO
NR8	NO	NO	NO	NO	NA	NONE	NA	NO	NO
NR9	YES	YES	NA	NA	YES	YES	YES	NO	NO
NR10	YES	YES	NA	NA	YES	YES	YES	NO	NO
NR11	YES	YES	NA	NA	YES	NONE	NA	NO	NO
NR12	NO	YES	NA	NA	YES	YES	YES	NO	NO
NR13	NO	NO	NO	NO	NA	NONE	NA	NO	NO
REGION COMPL %	5 of 13 = 38%	5 of 13 = 38%	0 of 7 = 0%	0 of 7 = 0%	5 of 5 = 100%	13 of 13 = 100%	4 of 5 = 80%	3	1

	CI Discuss	Interest	Plan to Educ	Plan Implem	Goals Set	Ident Barriers	Addressed Barriers	Med Complex	Behav Complex
REGION 3 SOUTHWEST									
SW1	NO	YES	NA	NA	YES	YES	YES	NO	NO
SW2	YES	YES	NA	NA	NO	NONE	NA	NO	NO
SW3	NO	YES	NA	NA	YES	NONE	NA	NO	NO
SW4	NO	YES	NA	NA	NO	YES	YES	YES	NO
SW5	YES	YES	NA	NA	YES	NONE	NA	NO	NO
SW6	NO	YES	NA	NA	YES	NONE	NA	NO	NO
SW7	NO	NO	NO	NO	NA	NONE	NA	NO	YES
SW8	NO	NO	NO	NO	NA	NONE	NA	NO	NO
SW9	NO	NO	NO	NO	NA	YES	YES	NO	NO
SW10	NO	YES	NA	NA	YES	YES	YES	NO	NO
SW11	NO	NO	NO	NO	NA	YES	NO	NO	NO
SW12	YES	YES	NA	NA	YES	YES	YES	NO	NO
SW13	NO	YES	NA	NA	YES	NONE	NA	NO	NO
SW14	NO	YES	NA	NA	NO	NONE	NA	NO	NO
SW15	NO	NO	NO	NO	NA	YES	NO	NO	NO
SW16	NO	NO	NO	NO	NA	YES	NO	NO	NO
SW17	NO	YES	NA	NA	YES	NONE	NA	NO	YES
SW18	NO	NO	NO	NO	NA	YES	NO	YES	NO
SW19	YES	YES	NA	NA	YES	YES	NO	NO	NO
SW20	NO	NO	NO	NO	NA	YES	YES	NO	NO
SW21	YES	YES	NA	NA	YES	YES	YES	NO	NO
SW22	NO	NO	NO	NO	NA	YES	NO	NO	NO
SW23	NO	NO	NO	NO	NA	NONE	NA	NO	NO
REGION COMPL %	5 of 23 = 22%	13 of 23 = 57%	0 for 10 = 0%	0 for 10 = 0%	10 of 13 = 77%	23 of 23 = 100%	7 of 13 = 54%	2	2

	CI Discuss	Interest	Plan to Educ	Plan Implem	Goals Set	Ident Barriers	Addressed Barriers	Med Complex	Behav Complex
REGION 4 CENTRAL									
CR1	NO	YES	NA	NA	NO	NONE	NA	NO	NO
CR2	NO	YES	NA	NA	NO	YES	NO	NO	NO
CR3	YES	YES	NA	NA	YES	NONE	NA	NO	NO
CR4	YES	YES	NA	NA	YES	NONE	NA	NO	NO
CR5	YES	YES	NA	NA	YES	YES	YES	NO	NO
CR6	NO	NO	NO	NO	NA	NONE	NA	NO	NO
CR7	NO	NO	NO	NO	NA	NONE	NA	NO	NO
CR8	NO	NO	NO	NO	NA	NONE	NA	NO	NO
CR9	NO	NO	NO	NO	NA	NONE	NA	NO	NO
CR10	YES	NO	NO	NO	NA	YES	NO	NO	NO
CR11	NO	NO	NO	NO	NA	NONE	NA	NO	NO
CR12	YES	NO	YES	YES	NA	NONE	NA	NO	NO
CR13	NO	NO	NO	NO	NA	NONE	NA	NO	NO
CR14	NO	NO	NO	NO	NA	NONE	NA	NO	NO
CR15	YES	YES	NA	NA	YES	NONE	NA	NO	NO
CR16	NO	YES	NA	NA	NO	NONE	NA	NO	NO
CR17	NO	NO	NO	NO	NA	NONE	NA	NO	NO
CR18	YES	YES	NA	NA	NO	NONE	NA	NO	NO
CR19	YES	YES	NA	NA	YES	NONE	NA	NO	NO
REGION COMPL %	8 of 19 = 42%	9 of 19 = 47%	2 of 12 = 17%	2 of 12 = 17%	5 of 9 = 55%	19 of 19 = 100%	1 of 3 = 33%	0	0

	CI Discuss	Interest	Plan to Educ	Plan Implem	Goals Set	Ident Barriers	Addressed Barriers	Med Complex	Behav Complex
REGION 5 EASTERN									
ER1	NO	NO	NO	NO	NA	NONE	NO	NO	NO
ER2	NO	NO	NO	NO	NA	NONE	NA	NO	NO
ER3	NO	NO	NO	NO	NA	YES	NO	NO	NO
ER4	NO	NO	NO	NO	NA	YES	YES	NO	NO
ER5 (1)	NO	NO	NO	NO	NA	NO	NO	CND	CND
ER6	NO	NO	NO	NO	NA	NONE	NA	NO	NO
ER7	YES	YES	NA	NA	YES	NONE	NA	NO	NO
ER8	NO	NO	NO	NO	NA	NONE	NA	NO	NO
ER9	NO	NO	NO	NO	NA	YES	YES	YES	NO
ER10	NO	NO	NO	NO	NA	NONE	NA	NO	NO
ER11	NO	NO	NO	NO	NA	NONE	NA	NO	NO
ER12	NO	NO	NO	NO	NA	NONE	NA	NO	NO
ER13	NO	NO	NO	NO	NA	YES	YES	NO	NO
ER14	YES	YES	NA	NA	NO	YES	YES	NO	NO
ER15	YES	YES	NA	NA	YES	NONE	NA	NO	NO
ER16	YES	YES	NA	NA	YES	YES	YES	NO	YES
ER17	YES	YES	NA	NA	YES	NONE	NA	NO	NO
ER18*	YES	NO	YES	YES	NA	YES	YES	NO	NO
ER19	YES	NO	YES	YES	NA	YES	YES	NO	YES
ER20	YES	NO	YES	YES	NA	YES	YES	NO	NO
ER21	NO	NO	NO	NO	NA	NONE	NA	NO	NO
ER22	NO	NO	NO	NO	NA	YES	NO	NO	NO
REGION COMPL %	8 of 22 = 36%	5 of 22 = 23%	3 of 17 = 18%	3 of 17 = 18%	4 of 5 = 80%	21 of 22 = 95%	8 of 12 = 67%	1	1

*ER5 (1) Records that document that these actions were properly implemented were not provided IX.C.)

CUMULATIVE TOTAL/%	36/100 = 36%	44/100 = 44%	5/57 = 9%	5/57 =9%	29/44 = 66%	98/100 = 98%	29/46 = 63%	8	10

KEY

* AR does not want CI

** Retired

*** Unable to work b/c significant medical

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

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 36% of the sample. In our 2021 and 2020 Study samples respectively, we found that 59% and 52% of the individuals had such discussions. The percentage of compliance across the five Regions in this study period ranged from 22% in Region 3 to 43% in Region 1. As was true for employment, we expected to find evidence of meaningful discussions that at a minimum included discussing the services available, the individual's skills, interests, challenges and barriers in order to find that a sufficient discussion occurred. The SCQR now includes the same seven elements that were discussed under the employment section, to determine if a meaningful discussion about ICI occurred.

DBHDS reported in its Case Management Steering Committee Report for FY22 that these, based on CSB reported data, discussions were held for 95% of all individuals during FY22 for whom an ISP was held. During the twelve-month period, ISPs were in the correct status for data reporting for 80% (12,396) of the 15,394 waiver participants who were at least eighteen years old.

Setting a CE Goal – It appears when comparing the interest in ICI between the samples in 2020 and 2021 that a similar percentage did not express interest in ICI. It is surprising that so many individuals in both samples were uninterested in ICI: only 42% in 2021 and only 44% (44 of 100 individuals) in 2022. 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 evidence of a continued lack of some CM's understanding of the definition of CE. This observation is based on the overall outcome of, and specifics found in the record review. It also may have been impacted by so many CE program closures during the COVID pandemic.

Many CMs continue to report that the very limited involvement individuals have in integrated community-based group activities offered by the center-based group day providers equates to community engagement. These activities do not meet the DBHDS criteria for what constitutes integrated

community activities. The group day activities are typically offered to more than individuals in one group than the maximum of three individuals which is a DBHDS criterion to be considered inclusive activities in the community when using CE. They also do not include significant or meaningful interaction with typical community members.

Sixty-six (66) percent of the individuals who expressed an interest also have an ICI goal (29 of 44 individuals). This compares to 55% of the sample who were interested in ICI and had goals in the 2021 IDA Study. Regions ranged from 45% in Region 1 to 100% in the Region 2 in the percentage of individuals who have an ICI goal. Using the same methodology DBHDS and CSBs use to calculate this percentage for determining the percentage of individuals with an ICI goal, the percentage of individuals with a goal for ICI is only 30%.

Interest in ICI and Plans to Educate Individuals and Families - The interest of the individual, family or Authorized Representative (AR) is noted by a checked box on the ISP. Overall, 44% of the individuals expressed an interest in ICI, compared to 33% expressing an interest in employment, and 56% of the individuals expressing having no interest in ICI at this time. These are similar findings to those in the 2021 IDA Study. DBHDS expects progress towards achieving the agreed upon compliance indicator measure by developing educational plans to address the obstacles to individuals interested in ICI. The lack of development of such plans and identification of obstacles has clearly hindered CSB and the Commonwealth's progress. For example, of the fifty-six individuals in the 2022 sample who were not interested in ICI, only 9% (5) of the individuals have a plan to further educate them about ICI. There was evidence that all five plans were being implemented. However, this is a slight increase since the 2020 study which found that 4% of the sample had a plan to educate the individuals/ARs further about the benefits of ICI.

Many CMs record that their plan was merely to simply ask each year whether the individuals, family or AR were interested in CE. Whereas we determined that there was an acceptable education plan in place and implemented when the CM documented specific strategies they would use to further the individual 's and family's interest and comfort with and understanding of ICI. CMs may achieve a higher percentage of educating 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 group day programs in large congregate settings. They may already volunteer, but on a limited basis and in large groups. The 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 ICI for 98% of the individuals on their caseloads who are in the sample, compared to 68% in the 2021 IDA Study sample. All teams either listed barriers or determined there were none that would impact the individual's participation in ICI. However, there is only evidence that barriers are being addressed for 63% (29 of 46 individuals with barriers noted), of the individuals in the sample, which is a significant improvement compared to 34% of last year's sample.

To achieve the compliance measures associated with ICI, it is critical that ISP teams become proficient in developing specific strategies to address and overcome barriers 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 few community-based activities as discussed earlier. These are individuals who may have fewer barriers to participating in ICI and whose teams could concentrate on assisting them to understand the benefits of ICI and addressing whatever barriers or hesitancies may exist that is keeping them from becoming engaged in community life and developing relationships with typical peers.

On Site Visit Tools (OSVT)- DBHDS did include the OSVTs that were completed by CMs for the individuals in the sample. We received records that indicates the OSVTs were regularly completed for 91 of the 100 (91%) individuals. The OSVT includes a question regarding the individuals' participation in community activities according to their plan. The form

includes an instruction for the CM to provide examples. We saw very few completed OSVTs that gave any information about this participation. If CMs provided examples consistently, they could be used by CM Supervisors to better determine if the community activities individuals engage in are inclusive, or just offer the person the chance to be present in the community.

Conclusions and Recommendations

The findings of this study conclude that the targets DBHDS set for both IDA discussions and IDA goals are not being met. Only forty (40%) individuals had a meaningful employment discussion, and thirty-six (36%) individuals had a sufficient discussion of CE. The discussions of employment are dramatically lower than those that were found to have occurred for the 2021 IDA Study sample (72%) and for ICI discussion for the prior study periods for ICI discussions (52%). Many CMs do not discuss employment 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.

The interest in employment and ICI remains surprisingly low with only 40% of individuals and ARs expressing an interest in employment and 44% of individuals and ARs expressing an interest in ICI. However, the interest in both employment and ICI has increased over our findings in the 2021 IDA Study when 26% were interested in employment and 42% were interested in ICI. We continue to see ARs who do not want employment opportunities explored for their family member; and some also do not want to explore ICI.

It does seem this hesitancy was influenced by COVID. These ARs often represent individuals who do not have a significant health or physical reason why employment cannot be pursued. After decades of experiences when employment and other integrated day activities were not offered or available, especially for individuals with complex needs, these ARs need much more information about employment and integration opportunities that are now available in order to more seriously consider it as the first and priority option for their family members. To view these integrated service options as viable and beneficial for their adult children, families may need opportunities to observe other individuals with similar characteristics in these programs.

The findings of this study support previous findings indicating 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. There continues to be little evidence that CMs have the practical knowledge and information to discuss the impact of employment on benefits. 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 be educated to 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.

Although required to do so by the Commonwealth, it is evident that CSBs are still not training or requiring 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 5% and 9% 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 and develop more concrete plans to address the barriers to employment and ICI that are identified if individuals are to select IDA rather than congregate day programs that offer limited opportunities for community integration and inclusion. CM supervisors must ensure that the CMs that they oversee are prepared and actually fulfill the Commonwealths expectations and requirements under the Settlement Agreement.

It remains apparent from a review of the 98 records in this sample that many CMs do not grasp what options should be offered through ICI. Many CMs continue to report that individuals in Group Day settings enjoy community inclusion or are receiving community engagement because the provider takes them to community activities. However, these outings are not typically individualized; are often 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.

We continue to believe supervisors are most likely the key to advancing cultural change via a more consistent training process and setting clear expectations especially for ICI for new CMs. This becomes more essential as the turnover in CM positions remains high or increases. 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. CMs need more training to make goals more specific and to develop measurable objectives to be able to reliably determine progress.

In this reporting period it was difficult to determine if provider capacity remains an issue for CE services. CE programs were closed due to COVID or lacked staff. Families were more reluctant to have their children in community settings for work or for inclusive activities. Many community options and jobs were not viable during the reporting period because of so many community program and employment closures.

The Parties negotiated and the Court has approved compliance indicators with precise measures for employment and CE discussions and goal setting. The SCQR process now includes a review of employment and CE expectations for discussion and goal setting. The current SCQR is more inclusive of the elements that should be included in a discussion for it to be meaningful. These criteria for what should be a sufficient discussion results in a much different and lower percentage of individuals who have had discussions included in their ISPs, than merely verifying that boxes have been checked without any documentation that demonstrates that a meaningful discussion actually occurred. Given the difference in our findings from the CSB reporting in the Semiannual Employment Reports, it is apparent the CSBs reporting is based on checked boxes rather than evidence of discussions. The DBHDS process for reviewing the data related to these CIs support that confirming the box is checked in the ISP is the methodology. These data are not reliable or valid and cannot be reported by DBHDS to demonstrate compliance with the related CIs. It remains a concern that DBHDS is not using the SCQR data to verify its compliance with the employment and community engagement CIs.

It is very 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 only able to share the raw data results from the SCQR FY22 SCQR interrater Reliability Results. Once the full report for FY22 is completed by the SCQR staff we can compare our findings.

CSBs and CMs should benefit from using the ISP version 3.2 as it should prompt more team discussion of employment and community inclusion. We understand a 3.3 version has been developed but did not review it. This version appears to require that the CM summarize what they actually discussed about employment and ICI services. Many CMs note a family does not want employment as a barrier without exploring with the family what brings them to the conclusion that they do not want to pursue employment for their child. 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 actually address the factual and perceived barriers. 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. CMs complete the On-Site Visitation Tool (OSVT) to document the monthly visits. There is a specific question if the goals for community inclusion are being met. The form indicates the CM is to give examples. We did not find that CMs did more than check yes for this query which cannot be considered a reliable indicator that there is evidence to support the check mark.

We are very aware of the impact the COVID pandemic had on individuals with IDD, their families and service availability during 2020 and 2021, stretching in some cases into 2022. The records we reviewed were primarily for calendar year 2021. For much of that time programs were closed, families wanted their children to stay at home, and there was less evidence of individuals working.

While we anticipated there would be less actual involvement in employment and CE, the short-term inability to assure consistent employment and community participation does not mean that there should not be discussion of

the interests, aspirations and concerns individuals and families have as they plan for their futures in a post-pandemic world. Nor does it indicate that individuals cannot be preparing or learning new skills at home or in a congregate day program that will contribute to greater inclusion and the opportunity to work in the future.

APPENDIX C

Transportation

by

Ric Zaharia, Ph.D.

Consortium on Innovative Practices

TO: Donald Fletcher, Independent Reviewer

FROM: Ric Zaharia, Ph.D.

RE: Period 21 Report - Transportation

DATE: November 14, 2022

Introduction

In addition to continuing to collect complaint data on NEMT transportation during the 19th Review Period, DMAS sustained its achievement of previously met indicators relating to contractual performance standards (16.1), separation of data for IDD users from general population users (16.3), opportunities for IDD users to participate on regional Advisory Boards (16.4), quarterly sampling of user satisfaction (16.5), and providing Medicaid recipients with information on complaint and appeal processes (16.6), and two focus groups centering on IDD users, which provided constructive feedback (16.7).

Regarding non-NEMT transportation, DBHDS's QSR vendor reported showing that at least 90% of those interviewed who received agency provided transportation reported having no problems, which exceeds the 86% benchmark in Compliance Indicator 16.8. The Commonwealth was likely to fully achieve this indicator if it continued to document this positive rate, include it in the QSR annual report to the QIC, and the Independent Reviewer verifies a Commonwealth finding that its reported data are reliable and valid.

In summary, during the 19th Period DMAS achieved six of eight Compliance indicators for transportation, Section III.C.8.a (16.1, 16.3-16.7). However, since Compliance Indicators 16.02 and 16.08 were not achieved, this Provision remained in non-compliance.

Summary of findings for 21st Period Review

During the 19th Review Period and subsequently, DMAS and the Independent Reviewer engaged in a dialogue to refine the Department's proposal to utilize encounter-based trip times to generate valid on-time performance data for NEMT transportation. The purpose of this 21st Period study of transportation is to determine whether achievement has been sustained for MET indicators (16.1, 16.3-16.7), whether 16.2 has been achieved, and whether DBHDS has sustained the achievement of the 86% benchmark in the QSR data and has determined, and this study verifies, the reported data to be reliable and valid (16.8).

DMAS has sustained its efforts for all previously met indicators. It's efforts to sustain the use of focus groups to gather input from IDD users and representatives are acknowledged. The three most recent groups (9.30.21, 12.15.21, 3.31.22) reflect vigorous input from IDD users' representatives and included parents, family members, providers, and advocates. Their input to DMAS staff included suggestions to provide training to group home staff on the Modivcare app, to ask Modivcare to set up an online complaint system, and to modify advance time to get approval for Gas Reimbursement; complaints included that drivers are responsive only 30% of the time and late 50% of the time. Hopefully, these are a useful source of data points which will allow DMAS to identify and pursue system improvements. Enthusiasm for participation in focus groups often wanes over time, unless participants learn of the improvements that result from their contributions. An acknowledgement or discussion of problems offered by the focus groups would improve the usefulness of the process (and minutes) to IDD users and their representatives. Focus group studies should be distinguishable from advisory boards, listening tours, etc. They should be learning opportunities that are reportable to the user community.

On-time performance by NEMT drivers is a long-standing complaint of the IDD user community. Requiring GPS based app technology of drivers and using a 15-minute window on either side of the appointment time as the definition of 'late', DMAS reported for Q4 FY22 that of 363,258 scheduled trips, 199,211 were on time. This resulted in an on-time performance rate of 54.8%, which is below the benchmark of 86%. This rate should improve once further DMAS and Modivcare analyses determine root causes, liquidated damage penalties based on GPS performance are levied, and all drivers are linked into this digital technology.

The third round of FY 22 QSRs (Quality Service Reviews) by the DBHDS contractor showed that 94% of the users of non-NEMT transportation reported no problems with their transportation. Considering the second round of FY21 results, interim reports, and an annual report to QIC, DBHDS has achieved this indicator.

In summary, during the 21st Period DMAS/DBHDS sustained achievement of seven of eight Compliance Indicators for transportation, Section III.C.8.a (16.1, 16.3-16.8), but DMAS did not achieve 16.2. Since Compliance Indicator 16.2 was not achieved, this Provision remains in non-compliance.

No curative actions were associated with this Provision. The findings for this review are summarized in Table 2 on the next page.

Process Document & Attestation

The Process Control document for the QSR and its Data Set Attestation form were reviewed and are complete. They are appropriately responsive to issues surrounding the QSR and raised in Independent Reviewer (IR) reports. The process steps are detailed and clearly stated. The numerator and denominator are correctly stated for the metric required in the Compliance Indicator 16.8 (86%). One controlling (limiting) element is identified for the whole QSR interview process in that there are a number of Cannot Determine (CND) ratings associated with many individual interview questions, but this issue is addressed through sample size.

DQV did not identify any issues threatening the reliability or validity of the QSR measure. The DBHDS Chief Information Officer reviewed and affirmed the integrity of the QSR information by attesting to the reliability and validity of the data that was collected for this Compliance Indicator.

Table 1 - Data Integrity Documents

	Process Control Documents	Data Set Attestation
16.8	DOJ Process TRANSPORTATION…(QSR-#15)	Data Set Attestation Form… (8.9.22-QSR-#16)

Compliance Indicator Achievement

Table 2 below recaps the status of the compliance indicators this study reviewed**.**

Table 2
Compliance Indicator Table
Transportation

#	III.c.8.a - Transportation	Facts	Analysis/conclusions	19th	21st
16.1	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.	The Commonwealth continued to include performance standards and timeliness requirements in its contracts. DMAS fined its fee for service contractor, Modivcare, $585,000 during FY22 for failure to meet performance or timeliness standards; half this amount was for "unfulfilled trips"; this is twice the amount of payment reductions for this provider as in FY21. (See #2).	Sustained achievement.	MET	MET
16.2	2. At least 86% of DD Waiver recipients using Medicaid non-emergency medical transportation (NEMT) will have reliable transportation.	In Q4 FY21 IDD members filed complaints at the rate of 715 for 395,150 trips – 97% were complaints against Modivcare and 94% of these were for vehicle availability (see #8). However, the IR did not accept this as an accurate metric for reliable transportation, so he and DMAS have negotiated a trip-encounter electronic measurement methodology (see #9, 12).	DMAS should continue their analysis to determine if there are variables associated with on-time performance and where root causes of delays may occur. This reliability rate should improve once liquidated damage penalties based on GPS performance are levied, and all drivers are digitized by linking to this technology. However, this indicator is not achieved in this cycle.	NOT MET	NOT MET

#	III.c.8.a - Transportation	Facts	Analysis/conclusions	19th	21st
		Requiring GPS based app technology tied to Google maps and a 15-minute window on either side of the scheduled appointment time as the definition of 'late', DMAS reported for Q4 FY22 363,258 scheduled trips of which 199,211 were on time. This resulted in an on-time performance rate of 54.8%, which is below the benchmark of 86% (see #14).			
16.3	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 has updated its contract with Modivcare (see #4), which continues to include the requirement to separate IDD users in its data analysis and quality improvement processes (see #6).	Sustained achievement.	MET	MET
16.4	b. Ensure DD Waiver users and/or their representatives have opportunities to participate in the regional Advisory Board; and	DMAS has updated its contract with Modivcare (see #4), which continues to include the requirement of ensuring DD Waiver users have opportunities to participate on Regional Advisory Boards (see #6). IDD waiver users continue to participate in regional advisory boards (see #11).	Sustained achievement.	MET	MET
16.5	c. Through a statistically valid sample of transportation users, surveys are conducted to assess satisfaction and to identify problems on a quarterly basis.	DMAS has updated its contract with Modivcare (see #4), which continues to include the requirement to survey statistically valid samples of users to assess satisfaction quarterly (see#6); the Q4 FY22 Modivcare satisfaction survey was reviewed and continues to show high	Sustained achievement.	MET	MET

#	III.c.8.a - Transportation	Facts	Analysis/conclusions	19th	21st
		levels of satisfaction (see #13); e.g., 77/77 users reported their driver was on time on both ends of the trip.			
16.6	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 has held five focus groups with IDD users/representatives since 2020. The three most recent groups (9.30.21, 12.15.21, 3.31.22) reflect vigorous input from IDD users and representatives and included parents, family members, providers, and advocates (see #7)	Sustained achievement.	MET	MET
16.7	5. DMAS provides all Medicaid recipients with information on processes for filing complaints or appeals related to their Medicaid services.	DMAS continues to provide Medicaid recipients with information on filing complaints or appeals (see #10).	Sustained achievement.	MET	MET
16.8	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	HSAG's Quality Service Review tool includes a satisfaction question regarding transportation during the individual interviews. The results have been: <u>-Round 2, FY 21</u>: 91% of the individuals interviewed who receive transportation from their waiver providers experienced no transportation problems -<u>Round 1, FY22</u>: 90% of the individuals experienced no transportation problems. <u>-Round 2, FY 22</u>: 91% of the individuals experienced no transportation problems. <u>-Round 3, FY22</u>: 94% of 1200 individuals who were interviewed and who receive transportation from their waiver providers experienced no	In the last four rounds of QSR reviews individuals receiving transportation from their waiver providers have reported rates higher than 86% having no problems with their transportation. These individually reported satisfaction rates, which can serve as a proxy for reliable transportation, are comparable to the rates Modivcare NEMT user samples have historically reported. Since the data integrity of these reports have been established, this compliance indicator is achieved.	NOT MET	MET

#	III.c.8.a - Transportation	Facts	Analysis/conclusions	19th	21st
	Medicaid services.	transportation problems (see #1, 17). Other QSR queries support that waiver provider (e.g., residential service providers) transportation has facilitated participation in community activities and Medicaid services: -Is there evidence of completion of annual physical exam….? -Is there evidence of an annual dental exam….? -Does the licensed provider encourage participation in community outings….? Do you attend religious services? (See #1) All reported positively in the 90+% range, except 'religious services' which was positive 52%. These results have been provided to the QIC in annual and quarterly reports, therefore this indicator is accomplished. Process Control documents (#15) and Data Set Attestation (#16) were reviewed.			

Recommendations:

1. DMAS should consider adding responses to the Focus Group Minutes 'Question & Comments section', in which problems raised by users are explained, rebutted, or placed on agendas for further research and action by DMAS; alternatively, DMAS might annually issue a report to users on the learnings from Focus Groups and activity generated as a result.
2. DMAS should consider identifying IDD users (in addition to parents and family members) who use Modivcare, who might be interested, and who might be invited to participate on a Focus Group.
3. DMAS should consider conducting full, ongoing analyses of the trip encounter data as more information becomes available
4. DMAS should re-evaluate the Modivcare satisfaction survey process.

Attachment A
Documents Reviewed

1. Quality Service Review Aggregate Report, Review 3 SFY2022, 6.17.22.
2. DOJ Modivcare FFS NEMT
3. VA Transportation Provider Agreement, 4.26.22.
4. DMAS – Contract 10041 Modification (Modivcare) – 2.21.22, 3.30.21, 12.11.18
5. Contract 10041 – Final Executed (Modivcare), 1.10.18
6. RFP 2018-01 NEMT Final 092017
7. Transportation Focus Group Meeting Minutes, 9.30.21, 12.15.21, 3.31.22
8. 4QFY2021 IDD FFS and MCO Total Complaint Report Summary
9. Proposed DMAS Transportation Performance Measures, 8.29.22
10. DMAS Responses to RZ 2022 Document Request,
11. Modivcare Advisory Board Meeting Webinar, 6.21.22
12. Proposed DMAS Transportation Performance Measures, 9.16.22
13. DMAS-IDD DD Waiver Customer Satisfaction Survey (Modivcare Q4 FY22)
14. DRAFT Measure Summary for IR, 9.29.22 (DMAS)
15. DOJ Process TRANSPORTAITON NON NEMT THROUGH QSR, 7.15.22
16. Attachment B, Data Set Attestation Form, 7.29.22 (QSR)
17. DBHDS Quality Service Review, Annual Summary, FY 2021, 9.30.21 (QIC document)

Attachment B

Transportation Interview

Name	Title	Date of Interview
Ann Bevan	Director, Division of High Needs Supports, DMAS	10.4.22
Aaron Moore	Transportation Services Unit Manager, DMAS	10.4.22
Heather Norton	Assist. Commissioner, Developmental Services, DBHDS	10.4.22

APPENDIX D

Regional Support Teams

by

Ric Zaharia, Ph.D.

Consortium on Innovative Practices

TO: Donald Fletcher, Independent Reviewer

FROM: Ric Zaharia, Ph.D.

RE: Period 21 Report: Regional Support Teams (RST)

DATE: October 27, 2022

Introduction

During the 19th Review Period in 2021 the problem of late non-emergency referrals continued for DBHDS review of large congregate setting admissions. Timeliness rates continued to be highly variable between CSBs and never reached the statewide 86% benchmark in Provision III.D. (Compliance Indicator 20.2). The Independent Reviewer noted that this variability allowed DBHDS to place individuals in larger congregate settings without prior RST review more that 14% of the time. Weaknesses in the RST data prompted DBHDS to conclude that one data integrity improvement was to move the RST process into WaMS.

The Independent Reviewer concluded that DBHDS had otherwise made substantial progress regarding RSTs, had conditionally met ten of thirteen compliance indicators in Section III.D.6, and had achieved Sustained Compliance with Provisions III.E.1-3. However, since DBHDS had not achieved Compliance Indicators 20.2, 20.7, and 20.12 and had not yet found the data sources for 20.4, 20.8. 20.10, and 20.13 to be reliable and valid for the purposes of compliance reporting, Provision III.D.6 was still in non-compliance.

Methodology

The purpose of this study of RSTs is to verify whether the Commonwealth has sustained achievement for Provision III.D.'s MET* indicators (20.1, 21.3-6, 20.8-11, 20.13), has sustained compliance with Provisions III.E.1-3, has achieved III.D.6's compliance indicators 20.2, 20.7, 20.12, and has determined that the data sources are reliable and valid for 20.4, 20.8. 20.10, and 20.13 pursuant to Compliance Indicator 36.1.

I reviewed Regional Support Team related documents/records (see Attachment A) and interviewed key personnel (see Attachment B) to gather and evaluate evidence, in order to verify that the Commonwealth has achieved and/or maintained compliance and to determine the status of Curative Actions. For the data sources related to the Provisions being studied, this review also evaluated and verified the extent to which the Commonwealth has fulfilled the data integrity requirements of V.D.3, in accordance with Compliance Indicator 36.1.

Summary of Findings 21st Period Review

DBHDS reported that the quarterly RST timeliness rates over the past fiscal year (FY22) ranged from 48% to 68% but never achieved the benchmark of 86%. This metric includes all three reasons (A-B-C) plus unreported referrals which DBHDS located through a WaMS cross check. DBHDS determined that focusing on Reason B ('individual or decisionmaker is planning to move without sufficient time for RST referral/review') would yield the largest and best impacts on RST referral timeliness. Those efforts appear successful because the rates for Reason B reduced from 23% to 10% of total referrals during FY22) but did not ultimately improve the overall timeliness rate. Therefore, DBHDS was not able to achieve compliance for Compliance Indicator 20.2.

DBHDS reported FY22 compliance rates for non-emergency RST referrals (Reason A: 'late primarily due to CSB delays') of 82% (518 timely referrals out of 629 total referrals). This falls below the FY 21 timeliness rate of 88% and below the 86% benchmark. Therefore, DBHDS was not able to sustain compliance for Compliance Indicator 20.4.

DBHDS has tracked individual CSB failure to achieve the 86% RST benchmark. DBHDS has provided technical assistance and issued CAPs since Oct. 2020. Six (6) CSBs have successfully achieved the benchmark through CAPs and seven (7) CSBs remain on the DBHDS Watch List for outstanding CAPs; one CSB has a repeat CAP within a year (now under "mandatory monitoring") and a second CSB has had an open CAP since April 2021 and will require additional remediation due to a failure to improve. Therefore, DBHDS was not able to achieve compliance for Compliance Indicator 20.7.

DBHDS has drafted the procedures needed to incorporate RST referrals into WaMS, including tracking of those not diverted from 5+ settings for annual review and re-offer. Although procedures and processes are competently designed and the transition to WaMS is underway with templates and flowcharts in place, a full system rollout is not scheduled until December 2022. Although a system improvement with potential and positive impacts for the CSB community, it is unlikely that this improvement in RST data integrity will immediately impact timeliness rates. Therefore, DBHDS was not able to achieve compliance for Compliance Indicator 20.12.

DBHDS conditionally met nine of thirteen compliance indicators in Section II.D.6 and sustained compliance with two of three compliance indicators in Section V.D.2-3. DBHDS maintained sustained compliance with Provisions III.E.1-3, but has not yet achieved Compliance Indicators 20.2, 20.7, and 20.12 and did not sustain compliance with Compliance Indicator 20.4. Further, since DBHDS has not yet found the data sources for 20.4, 20.8. 20.10, and 20.13 to be reliable and valid for the purposes of compliance reporting, Provision III.D.6 was still in non-compliance

Process Documents & Attestation

DBHDS has labored on the data integrity of the RST process over the past few years. The current process is based on a manual entry of a paper form by the case manager, which ODQV determined in 2020 to be inadequate to improve reliability and validity of RST data and recommended incorporation of the RST process into WaMS. The transition to WaMS is underway with templates and flowcharts in place, training previews planned over the next few months, and a full system rollout scheduled for December 2022, during the 22nd review period. It is clear that user interfaces and data tracking will be improved following the transition of RST processes into WaMS.

No data integrity documents were provided for the current manual RST referral system, but it is anticipated that a Process Control Document and associated Attestations will be available after the full system rollout in the 23rd review period.

Curative Actions

DBHDS established a cross-regional RST team which has begun reviewing all referrals with insufficient time for full RST review. As an operational step in DBHDS's Curative Actions, the cross-regional team appears to have been successful in reducing the cases where the individual chose to move before RST review. Table 2 recaps the status of all Curative Actions for RST.

Table 1

Curative Action Status

CI 20.2 (III.D.6l) DBHDS is in compliance with the agreement when 86% of all statewide noni-emergency referrals, as such referrals are defined in the DBHDS RST Protocol, meet the timeliness requirements of the DBHDS RST Protocol.	Curative Action	Status
	Implement electronic process (Waiver Management System) - by January 15, 2022	System training and previews are planned for 11/22 with full system rollout 12/22. I reviewed the preview training demo and concluded that this change will positively impact user interface and overall data integrity.
	Complete a review of "Reason B" problems to see if DBHDS could impact them (Pareto chart, RST member input) - by November 2021	DBHDS determined that focusing on Reason B ('individual or decisionmaker is planning to move without sufficient time for RST referral/review') would yield the largest/best impacts on RST referrals.
	Present initial fix strategies to DOJ – December 2021[Q2 FY22]	CMSC surveyed RST members for recommendations to address timeliness issues. I reviewed the preview training demo for RST incorporation into WaMS and concluded that this change will positively impact user interface and overall data integrity.
	Implement fix strategies – January – March 2022,[Q3 FY22]	Cross-regional RST team was launched Q3 FY22. Full system rollout of RST incorporation into WaMS is scheduled for 12/22, Q2 FY23
	Report %, including "Reason B" each quarter – expect to start to see improvement in outcome % for "Reason B" by FY22 Q3 Report (finalized May 2022)	Cross-regional RST team implemented processes on RST referrals that appear successful at reducing the rates for Reason B by the end of FY22.

Compliance Indicator Achievement

Table 2 recaps the status of the compliance indicators this study reviewed.

Table 2
Compliance Indicators

#	III.D.6 – RST Compliance Indicators	Facts	Analysis/Conclusions	19th IR Report	21st IR Report
20.1	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.	DBHDS continues to track quarterly the timeliness and compliance of referrals per the RST Protocol (see#10, 15, 20).	Sustained achievement.	MET	MET
20.2	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. [*UNADJUSTED "A-B-C" RATE]	DBHDS reported the RST timeliness rates as: Q4 FY21 - 72% Q1 FY22 - 48% Q2 FY22 - 62% Q3 FY22 - 68% Q4 FY22 – 68% (See#10,15, 20, 22-23). This 15-month period is below the benchmark of 86%. This metric includes all 3 reasons (ABC) plus unreported referrals DBHDS located. For this review, 69 referrals during April-May 2022 were reviewed and spot-checked for compliance with the RST process (#3).	DBHDS determined that focusing on Reason B (individual or decisionmaker is planning to move without sufficient time for RST referral/review) would yield the largest/best impacts on RST referrals. Those efforts appear successful at reducing the rates for Reason B (23% to 10% over FY22), but not the overall timeliness rate. In general, these spot checks showed alignment between DBHDS requirements and CSB responsiveness. The most difficult individual situations in the system are recorded in the RST referral process. Also, see recommendations below. DBHDS has not achieved this benchmark over the last year.	NOT MET	NOT MET

#	III.D.6 – RST Compliance Indicators	Facts	Analysis/Conclusions	19th IR Report	21st IR Report
20.3	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.	DBHDS continues to conduct quarterly cross checks of WaMS authorization data GH+5 against RST referrals (see #1, #10, 15, 20). For Q4 FY22 twenty (20) individuals were not processed via RST and began living in GH±5 before RST review.	Sustained achievement.	MET	MET
20.4	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. [ADJUSTED "A" RATE]	DBHDS reported compliance rates for non-emergency referrals (late primarily due to CSB delays) of: 77% - Q1FY22 88% - Q2FY22 84% - Q3FY22 83% - Q4FY22 (See #5,10,15, 20, 22-23) For April-May 2022 69 referrals were reviewed and spot-checked for compliance with the RST process (#3).	DBHDS failed to sustain this achievement in FY22, which had 518 timely referrals out of 629 total referrals for a metric of 82%. This falls below the FY 21 timeliness rate of 88% and below the 86% benchmark. Also, see above at 20.2 and recommendations below. Therefore, compliance is not sustained.	MET*	NOT MET
20.5	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. [ADJUSTED "A" RATE]	DBHDS continues to review all RST submissions for compliance (see #10, 20) to hold CSBs accountable (see #2); for April-May 2022 69 referrals were reviewed and spot-checked for compliance with the RST process (#3).	Sustained achievement.	MET	MET
20.6	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. [ADJUSTED "a" RATE]	DBHDS continues to require CAPs of CSBs who referred less than 86% of the required cases through the RST process (see #2 & #4). Based on their FY 21 & 22 performance, seven (7) CSBs were required to submit CAPs pursuant to this requirement.	Sustained achievement.	MET	MET

#	III.D.6 – RST Compliance Indicators	Facts	Analysis/Conclusions	19th IR Report	21st IR Report
20.7	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. [ADJUSTED "a" RATE]	DBHDS has tracked CSBs' RST timeliness, CAPs, and training interventions since Oct. 2020 (see #4); seven (7) CSBs remain on the DBHDS Watch List for outstanding RST CAPs; one CSB has a repeat CAP within a year (now undergoing mandatory monitoring) and another CSB has had an open CAP since April 2021; both are projected to require additional remediation if there aren't improvements in FY23. Two CAPs, one open and one closed, were reviewed for this study. This review found that the related CAPs were appropriately targeted and underwent DBHDS scrutiny before finalization (see #16). DBHDS has not yet exercised contract sanctions to improve the performance of underperforming CSBs.	DBHDSs struggle with some CSBs and their lack of substantive progress despite CAPs suggests the performance of some CSBs is not changing, even after filtering out cases beyond the CSBs control. Therefore, additional technical assistance, remediation and/or sanctions are warranted and required. Not yet achieved.	NOT MET	NOT MET
20.8	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 continues to review data and survey the RST membership annually on suggestions to revise and improve the timeliness of referrals (see #17). DBHDS has drafted the procedures needed to incorporate RST referrals into the WaMS. As part of the transition of RST into WaMS the referral format is undergoing	Sustained achievement.	MET*	MET*

#	III.D.6 – RST Compliance Indicators	Facts	Analysis/Conclusions	19th IR Report	21st IR Report
		revision to incorporate input from RSTs, CRCs and case managers (see #9a-e).			
20.9	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 IR settings with 5 or more individuals.	CRCs continue to work creatively with individual cases to find the most integrated living situations (see #18)	Sustained achievement.	MET	MET
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.	DBHDS continues to issue the Provider Data Summary (PDS) with a focus on provider development (see #6-7), including RST data regarding barriers to placement in integrated settings, geographical distributions of services and gaps in services, underserved areas and opportunities for provider development, expansion opportunities for Jump-Start funding, and improvements in utility of the Baseline Measurement Tool for provider market research (e.g. narrowing the number of unique providers offering a particular service in each locality).	Sustained achievement.	MET*	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 continues to utilize their 1.29.21 Emergency Slot Request Process (see #8).	Sustained achievement.	MET	MET
20.12	12. DBHDS will add data related to the RST referral process to the Waiver Management Information System	DBHDS has drafted the procedures needed to incorporate RST referrals into the WaMS (see #9a-e), including tracking of	WaMS procedures and processes for RST are competently designed but have not been implemented.	NOT MET	NOT MET

#	III.D.6 – RST Compliance Indicators	Facts	Analysis/Conclusions	19th IR Report	21st IR Report
	(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.	those not diverted from 5± settings for annual review and re-offer. A cross-regional RST monthly team implemented a secondary review process on RST referrals that appears to have been successful at reducing the rates for Reason B (see #23, 25). RST tracking data is updated periodically with CSBs to ensure a complete RST database relative to offering options and ensuring choice (#12-13).			
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 continues to track and provide notice quarterly to CSBs of those who chose less integrated settings that were not available (see #11, 13). Five (5) such individuals were identified as of 9.30.22. Automated notices from RST to CSBs are sent annually to remind CSBs of individuals who preferred more integrated settings but accepted larger settings (#12). Standing information on new services and options is continuously available to CSBs. through two search directories, one at the Office of Licensing, the other through the MyLifeMyCommunity website (see #24). Although no unique announcement of new	Sustained achievement.	MET*	MET*

#	III.D.6 – RST Compliance Indicators	Facts	Analysis/Conclusions	19th IR Report	21st IR Report
		providers is made, CRCs are notified of new providers and share the availability of new providers with their regions and case managers.			

#	Previously reviewed Sections.	Facts	Analysis/Conclusions	19th IR Report	21st IR Report
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, 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.	Documentation reviewed indicate and Provider Development staff report no changes to roles or reporting structures. CRCs continue to work creatively with individual cases to find the most integrated living situations (see #18)	Sustained achievement.	MET	MET
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.	Documentation reviewed indicate and Provider Development staff report no changes to roles or reporting structures. CRCs continue to work creatively with individual cases to find the most integrated living situations (see #18)	Sustained achievement.	MET	MET
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	Documentation reviewed indicate and Provider Development staff report no changes to roles or reporting structures.	Sustained achievement.	MET	MET

#	Previously reviewed Sections.	Facts	Analysis/Conclusions	19th IR Report	21st IR Report
	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.				

VA#	V.D.2-3: Valid and Reliable Data (applied to the above identified indicators)	Facts	Analysis/Conclusions	19th IR Report	21st IR Report
36.1	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	DBHDS has labored on the data integrity of the RST process over the past few years. The current process is based on manual entry by the case manager, which ODQV determined in 2020 to be inadequate to improve reliability and validity of RST data (see # 31). DBHDS updated its Annual Data Quality Monitoring Plan for RST et al (see #14). The DQMP documents the expected transition of the RST process into WaMS.	Provider Development staff report a planned 12/22 rollout. A DQMP update after the transition is expected in CY 2023, therefore this indicator is not yet achieved.	NOT MET (related to the RST only)	NOT MET (related to the RST only)

	origination, and data uniqueness.				
36.5	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.	Provider Development staff report that KPAs remain unchanged.	Sustained achievement.	MET (related to the RST only)	MET (related to the RST only)
37.7	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.	DBHDS updated its Annual Data Quality Monitoring Plan for RST et al (see #14) and reported the vulnerability of manual RST referrals to user interface errors. The DQMP documents the expected transition of the RST process into WaMS.	ODQV provided its second annual DQMP addressing RST. Provider Development staff are planning a 12/22 rollout of the WaMS based RST. A DQMP update after the transition is expected next year. Therefore, this indicator is in sustained compliance.	MET (related to the RST only)	MET (related to the RST only)

Recommendations:

1) DBHDS should consider re-educating the provider community regarding RST processes and then implement consequences for provider admissions or transfers without advance CSB notification, e.g., billing claw back for days where CSB was not aware of transfer or admission.
2) After multiple quarters of non-achievement of the 86% benchmark, DBHDS should consider implementing consequences for CSB delays in making timely RST referrals or transfers, pursuant to the Performance Contract.
3) Based on this review of 69 referrals, DBHDS should consider a deeper dive into cases where an individual is moved to a nursing facility without CSB notification; given PASRR reporting requirements to OIH, there should be the ability to promptly (automatically) notify the CSB of an admission to a nursing facility.
4) Based on this review of 69 referrals, DBHDS should consider an evaluation of the closure process of a group home. Provider contracts and licensing regulations should stipulate a sufficient advance notice of planned closure, in order to avoid crisis placement. (Are individuals, authorized representatives, CSBs and DBHDS notified with sufficient advanced notice to allow for robust planning, choice and RST referral, if needed?)

Attachment A

Documents Reviewed

1. FY22 2ndQ WaMS Report (data comparison for missed referrals)
2. CAP request letters 8.5.22 (WT, VB, Southside, Henrico, Chesterfield, Crossroads.)
3. CRC RI (RST referrals for 69 individuals, April-May 2022)
4. CMSC CAP Watchlist and Process Map (8.2.22)
5. CMSC Recommendations letter to Commissioner, 6.3.22 & 12.20.21
6. Provider Data Summary Report May 2022, 7.21.22
7. PDS State of the State Slides, (PowerPoint)7.25.22
8. Emergency Slot Request Process, 1.29.21.
9. a.) RST Referral Steps for WaMS (3.21.22 draft); b.) VIC Steps for WaMS, 3.14.22 (draft); c.) RST WB v Eric (draft RST tracking report); d.) WaMS Data and Reporting Request Form, v7, 3.1.22; e.) Less Integrated and UTD referral data for OISS DR 2 (draft for annual review of those in less integrated settings)
10. FY22 2nd Quarter RST Report, undated.
11. FY22 2nd Q DBHDS RST Chart (plus quarterly notices to 40 CSBs)
12. FY20 Information Needed RST referrals (12 CSBs), 9.16.22
13. DR0023 Less Integrated Referrals, 7.1.19 to 6.30.20.
14. DQMP Annual Update, June 2022
15. CSB Late Chart RST Data FY22 Q3
16. Corrective Action Plans (Rockbridge-1.31.22, HNN-4.21.21)
17. RST Member Survey, 2022
18. CRC RST Examples, 9.16.22
19. Email, Williams to Zaharia, 10.3.22
20. FY22 3rd Qtr. RST Report Final
21. Data Quality Plan, Reporting Assessment (RST-May 2020)
22. FY22 4th QTR CSB Late Chart RST…10.7.22
23. CMSC Report FY22 3rd and 4th Qtr., 10.14.22
24. Email, Williams to Zaharia, 10.20.22
25. Curative Action CRT Notes, 8.17.22, 7.20.22, 6.15.22, 5.18.22

Attachment B

RST Interviews

Name	Title	Date of Interview
Eric Williams	Director, Provider Development, DDS	9.30.22

APPENDIX E

Mortality Review

by

Wayne Zwick, MD

PART I.

To: Donald Fletcher, Independent Reviewer

From: Wayne Zwick, MD

Re: Mortality Review Committee Process Monitoring

Date: 10/28/22

Re: Review of the Mortality Review requirements in the Settlement Agreement, U.S. vs. Commonwealth of Virginia

The 19th period review found that the MRC (Mortality Review Committee) continued to make advances toward fulfilling the requirements of the fifteen compliance indicators and thirty- nine sub – indicators for V.C.5. With the assistance of the Specialized Investigations Unit (Office of Licensing) and new regulations allowing access to medical records from several sources, the number of unknown deaths has decreased. Based on the rich data base available through these improvements in obtaining medical information, the number of deaths that the MRC categorized as potentially preventable increased. Based on more complete medical information, more accurate causes of death, demographic information, and other parameters led to the MRC's ability to track reliable quality data. Tracking of action steps recommended by the MRC were monitored to closure. A meticulous process has been put in place, with strides in reducing unreported deaths. The main challenge was an inability to sustain MRC review of unexpected death within 90 days of the death.

This is the report of the 21st 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 Settlement Agreement's mortality review provision V.C.5. and its associated compliance indicators 33.1-33.21. This review encompasses a full year of progress and change (August 2021 through July 2022). 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. This report also provides monitoring results of the curative actions agreed upon by the parties concerning the mortality review process, as well as verify the accuracy/reliability used in completion of the eMRF (electronic mortality review forms) document used as a source of information at the MRC meetings. From February 2022 through July 2022, there was marked improvement in achieving the review of unexpected deaths within 90 days, however the related compliance indicators (33.13 and 33.15) were not achieved. For deaths identified as potentially preventable by the MRC, determination of the appropriate level of prevention strategy occurred for each such death beginning with the January 2022 MRC meetings. Data reviewed for accuracy and reliability in the MRC process was verified.

Methodology

The findings and conclusions of this review are based interviews and on the documents provided and information shared at the time of the conference call 10/11/22.

Telephone interviews were with the following DBHDS staff: Dr. Aplasca (Chief Clinical Officer), Dr. Patricia Cafaro (MRT Clinical Manager), Robert Rigdon (MRC clinical reviewer), Whitney Queen (Mortality Review Program Coordinator), Susan Moon (Director of the Office of Integrated Health), Angelica Howard (SIU Office of Licensing) , and Heather Norton (Assistant Commissioner, Developmental Services)

The following documents were submitted for review:

Mortality Review Committee meeting minutes documentation and Mortality Review Committee Meeting Notes Summary documentation for each of the following dates: 8/12/21, 8/26/21, 9/9/21, 9/23/21, 10/14/21, 10/28/21, 11/4/21, 11/18/21, 12/2/21, 12/16/21, 1/13/22, 1/27/22, 2/10/22, 2/24/22, 3/10/22, 3/24/22, 4/14/22, 4/28/22, 5/12/22, 5/26/22, 6/09/22, 6/23/22, 7/14/22, 7/28/22, 8/11/22, 8/25/22.

Master Document Posting Schedules (MDPS): August 2021- July 2022

Orientation and Training: Definitions Updates December 2021, MRC Orientation July 2022 (pdf/PowerPoint format), July 28, 2022 Approved DBHDS MRC meeting minutes, December 2, 2021 DBHDS MRC Meeting minutes, MRC member confidentiality forms (March 2020-July 2022)

Reports to Commissioner: MRC Quarterly Report to Commissioner- 04 FY21, 01 FY22, 02 FY22, 03 FY 22.

Electronic Mortality Review Forms (eMRFs) for MRC meetings: 8/12/21, 8/26/21, 9/9/21, 9/23/21, 10/14/21, 10/28/21, 11/4/21, 11/18/21, 12/2/21, 12/16/21, 1/13/22, 1/27/22, 2/10/22, 2/24/22, 3/10/22, 3/24/22, 4/14/22, 4/28/22, 5/12/22, 5/26/22, 6/09/22, 6/23/22, 7/14/22, 7/28/22, 8/11/22, 8/25/22.

MRC Quarterly Data Reports: Q4 2021 Final, Q1 2022 Final, Q2 2022 Final, Q3 2022 Final.

Monthly MDPS: August 2021 through July 2022.

Sample Selection of primary document review for verification (24 Tier 1 individuals).

Mortality Review Charter, QIC Approval September 27, 2021, draft revised FY 22.

DW0080a Report (generic blank category headings).

Potential Unreported Deaths Log FY 22 (July 2021 – June 2022).

SFY21 DBHDS Annual Mortality Report 12.22.21 Final.

Email chain for confirmation of SFY21 DBHDS Annual Mortality Report 12/30/21.

DD Quality Management Plan SFY 2021, dated May 15, 2022.

MRC Quality Improvement Initiatives July 1, 2021 through June 30, 2022.

FY 2022 Mortality Review Committee Action Tracking Log.

FY 2023 Mortality Review Committee Action Tracking Log.

Information Requested for 21st DOJ MRC Study OHR.

MRC Table of Requested info 8.1.21 through 7.31.22.

Appendix A – INVESTIGATIVE PROCEDURES – Reviews for Connect August 2022.

Appendix C- DD DEATH INVESTIGATIONS - Revised for Connect August 2022

Appendix E – INVESTIGATION TEMPLATES – Revised Connect August 2022.

Facility Query Run Dates 8.01.21 thru 7.31.22.

Monthly DW0080aCommunication - SIU.

MRC Process Doc revised August 2021.

Document: 29.1, 37.4, 37.8 Commonwealth of Virginia Mail Fwd SFY 21 DBHDS DD QM Plan 5.16.22

Document: 29.1, 37.4, 37.8 Commonwealth of Virginia Mail [External] SFY 21 DBHDS DD QM Plan 5.17.22

33.13_ 33.15 Attachment B Data Set Attestation 07.29.22

33.9 Attachment B Data Set Attestation 07.29.22

Joint Filing of Agreement on Curative Action Attachment 1 as filed 11.19.21

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 multiple 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	
33.1	MRC Charter components and procedures	Draft revised FY22 Mortality Review Charter (QIC approved September 27, 2021)	19th X 21st X		This review verified that the MRC Charter Draft FY22 document includes all the elements required by Compliance Indicator 33.1 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 (I/DD), utilizing an information management system to track the referral and review of these individual deaths."	19th X 21st X		See the verification comment for 33.1 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	19th X 21st X		See the verification comment for 33.1 above.
b.	Executive sponsor within DBHDS	DBHDS Commissioner	19th X 21st X		See the verification comment for 33.1 above.
c.	Membership of MRC by role	Membership is listed in the charter according to title and role.	19th X 21st X		See the verification comment for 33.1 above. See ATTACHMENT 2A (#33.1) for quoted content concerning this process area.
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."	19th X 21st X		See the verification comment for 33.1 above.
e.	Frequency of meetings	"The MRC meets at a minimum, on a monthly basis or more frequently	19th X 21st X		See the verification comment for 33.1 above.

		as necessary to conduct mortality reviews within 90 days of death."			
f.	Review of unexplained and unexpected deaths	The process for review of unexplained/ unexpected deaths is described in the Charter.	19th X 21st X		See the verification comment for 33.1 above. See ATTACHMENT 2B for quoted content concerning this process area.
f.	Components of a complete mortality review	The process for review of a complete mortality review is described in the Charter.	19th X 21st X		See the verification comment for 33.1 above. See ATTACHMENT 2C for quoted content concerning this process area.
f.	Standards for closing a review	The process for closing a review is described in the Charter.	19th X 21st X		See the verification comment for 33.1 above. See ATTACHMENT 2D for quoted content concerning this process area.
f.	Standards for Committee quorum	The definition of quorum is described in the Charter.	19th X 21st X		See the verification comment for 33.1 above. See ATTACHMENT 2E for quoted content concerning this process area.
f.	Standards for Recusal from case review	The standards for recusal from a case review are described in the Charter.	19th X 21st X		See the verification comment for 33.1 above. See ATTACHMENT 2F for quoted content concerning this process area.
	Standards for Confidentiality protections for reviews	The standards for Confidentiality protections for reviews are described in the Charter.	19th X 21st X		See the verification comment for 33.1 above. See ATTACHMENT 2 G for quoted content concerning this process area.
g.	Definition of unexplained deaths	Included in the definition of unexpected death is the statement: "An unexplained death is considered an unexpected death."	19th X 21st X		See the verification comment for 33.1 above.
g.	Definition of unexpected deaths	The definition for 'unexpected deaths' is described in the Charter.	19th X 21st X		See the verification comment for 33.1 above. See ATTACHMENT 2 H (CI #33.1.) for quoted content concerning this process area.
h.	Requirements for periodic review and analysis at individual service level	The requirements for periodic review and analysis at individual service level are documented in the Charter.	19th X 21st X		See the verification comment for 33.1 above. See ATTACHMENT 2 I(i) (CI 33.1)
h.	Requirements for periodic	The requirements for periodic review and	19th X		See the verification comment for 33.1 above. See ATTACHMENT 2

	review and analysis at system level	analysis at the system level are documented in the Charter.	21st X		I(i)(CI 33.1)
h.	Develop and implement QI initiatives to reduce mortality rates	The Charter reviews the MRC role to develop and implement QI initiatives to reduce mortality rates	19th X 21st X		See the verification comment for 33.1 above. See ATTACHMENT 2 I(i) (CI #33.1)
h.	Reporting of QI initiatives to the QIC	The Charter reviews the reporting of QI initiatives to the QIC.	19th X 21st X		See the verification comment for 33.1 above. See ATTACHMENT 2 J (CI 33.1h)
C1#	Compliance Indicator Requirement	Evidence in DBHDS's submitted documentation	Status MET	Status NOT MET	Factual verification and analysis
33.2	Current MRC membership	The MRC membership is specified in the MRC charter (See ATTACHMENT 2A). All MRC meeting minutes included attendance rosters with titles/represented departments/roles.	19th X 21st X		This study verified that DBHDS achieved the requirement for Compliance indicator 33.2 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	19th X 21st X		See the verification comments for 33.2 above. This was fulfilled by the CC) (Chief Clinical Officer - MD) being the chair; additionally, the co-chair was the MRO clinical manager (NP). The CCO attended 23 of 24 MRC meetings during the year reviewed. The CCO attended 24 of 24 meeting during the year reviewed.
b.	DBHDS Senior Director of Clinical Quality Management (former Asst Commissioner for QI)	Same as above	19th X 21st X		See the verification comments for 33.2 above. There were several staff representing QI, either as primary attendees or as alternates through the 12 months of MRC meetings reviewed: Compliance/ Risk Management (3), Clinical/Community QI (3)
c.	Independent practitioner	One MD who was the independent clinician for the MRC	19th X 21st X		See the verification comments for 33.2 above. A review of the MRC meeting minutes verified that the

					Independent practitioner attended 22 of 24 (91.6%) of the MRC meetings during the year time period reviewed..
d.	Medical doctor	COO and independent practitioner	19th X 21st X		See the verification comments for 33.2 above. The attendance roster included 2 MDs that participated (the CCO and independent practitioner).
e.	Nurse	MRC meeting minutes attendance rosters with members identified with title/department	19th X 21st X		See the verification comments for 33.2 above. There were RNs (4) and NPs (2) indicated on attendance roster.
f.	QI staff	Same as above	19th X 21st X		See the verification comments for 33.2 above. There were several staff representing QI, either as primary attendees or as alternates: Clinical/Community QI (3). Compliance/Risk Management (3)
g.	Programmatic/ operational staff	Same as above	19th X 21st X		See the verification comments for 33.2 above. DMAS member (1), incident management (3), compliance (2), OHR (3), specialized investigation unit (2), OIH (2),MR coordinator (1), SA member (1), clinical reviewer (4), PharmD (1), DQV (1)
C1#	Compliance Indicator Requirement	Evidence in DBHDS's submitted documentation	Status MET	Status NOT MET	Factual verification and analysis
33.3	MRC member training topics to members				
a.	Orientation to MRC Charter scope, mission, vision, charge, and function of the MRC	Two training documents were submitted for power point presentations which occurred on 12/2/21 and 7/28/22. See ATTACHMENT 3 (C1 #33.3 a-d), for details.	19th X 21st X		This study verified that DBHDS achieved the requirement for Compliance indicator 33.3. The content of the training on 7/28/22 included the required criteria for orientation training. Training was determined by cross referencing to the prior 19th period review to determine who had been trained, and determining those present at the training on 7/28/22. Each MRC participant/attendee had proof a Confidentiality statement was

					completed. At the conference call with the MRT members, it was confirmed the date of the signed Confidentiality statement was the date of the training for three new members which included orientation to the MRC. Additionally, a discussion of the updated training of 12/2/21, and review of confidentiality statements indicated training was completed, and going forward, an improved record keeping system was needed to capture this information. See Attachment 3 C1#33 a-d.
b.	Prior to participation, review policies , processes, and procedures of the MRC	See above	19th X 21st X		Same as above
c.	Education on the role/responsibilities of members	See above	19th X 21st X		Same as above
d.	Training on continuous QI principles	See above	19th X 21st X		Same as above
C1#	Compliance Indicator Requirement	Evidence in DBHDS's submitted documentation	Status MET	Status NOT MET	Factual verification and analysis.
33.4	MRC functional requirements				
33.4	Frequency: meets at least monthly	Submitted were copies of the MRC meeting minutes and MRC meeting notes summaries for 24 meetings from 8/12/21 to 7/28/22	19th X 21st X		This study verified that DBHDS achieved the requirements for Compliance Indicator 33.4. This determination was made based on a review of MRC meeting minutes and MRC meeting notes summaries. See Attachment 4a. for dates of MRC minutes and notes summaries
33.4	Quorum met for each	The MRC charter defines a quorum as: "50% of	19th X		This study verified that DBHDS achieved the requirements for

	monthly meeting	voting 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."	21st X		Compliance Indicator 33.4 a.-e. See Attachment 4b.
a.	Medical Clinician (medical doctor, nurse practitioner, or physician assistant) required for quorum	MRC meeting minutes attendance roster	19th X 21st X		This study verified that DBHDS achieved the requirements for Compliance Indicator 33.4 a. From 8/12/21 through 7/28/22 there was a medical clinician at each meeting.
b.	Clinician with experience in mortality review required for quorum	As above	19th X 21st X		This study verified that DBHDS achieved the requirements for Compliance Indicator 33.4 b.. From 8/12/21 through 7/28/22 there was a clinician with experience in mortality review at each meeting
c.	QI professional staff required for quorum	As above	19th X 21st X		This study verified that DBHDS achieved the requirements for Compliance Indicator 33.4 c. From 8/12/21 through 7/28/22 there was a QI professional staff at each meeting.
d.	Programmatic/operational professional staff required for quorum	As above	19th X 21st X		This study verified that DBHDS achieved the requirements for Compliance Indicator 33.4 d. From 8/12/21 through 7/28/22 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	19th X 21st X		This study verified that DBHDS achieved the requirements for Compliance Indicator 33.04 e.

		review.			
C1#	Compliance Indicator Requirement	Evidence in DBHDS's submitted documentation	Status MET	Status NOT MET	Factual verification and analysis
33.5	DBHDS information management system				
33.5	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.	19th X 21st X		This review verified that the 'Mortality Review Committee Action Tracking Log' identified recommendations from 8/12/21 - 7/28/22. The MRC tracked all recommendations through to closure or continued pending status as of 8/11/22 for MRC meetings from 8/12/21 - 7/28/22. See ATTACHMENT 5.
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 included a section for Case Review 'Actions' along with assigned member of the committee. Additionally, each MRC meeting minutes included an agenda item entitled 'MRC Recommendation Update' which documented the number of recommendations that were agreed upon by the MRC as having been completed, based on information recorded in the MRC Action Tracking	19th X 21st X		This review verified that the 'Mortality Review Committee Action Tracking Log' identified recommendations from 8/12/21 - 7/28/22. The MRC tracked all recommendations through to closure or continued pending status as of 8/11/22 for MRC meetings from 8/12/21 - 7/28/22. Evidence of tracking was recorded in detail in the Mortality Review Committee Action Tracking Log. See ATTACHMENT 5

		Log.			
33.5	Track QI initiatives approved by MRC chair for implementation	When there was implementation of QI initiatives, tracking was reflected in the minutes of the MRC at periodic intervals	19th X 21st X		This study verified that DBHDS achieved the requirements for Compliance Indicator 33.5. See ATTACHMENT 6 for details.
C1#	Compliance Indicator Requirement	Evidence in DBHDS's submitted documentation	Status MET	Status NOT MET	Factual verification and analysis
33.6	Licensing responsibility with death reviews				
33.6	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.	19th X 21st 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 33.6 during the 21st 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. See ATTACHMENT 7 for data.
33.6	DBHDS Licensing Investigations Team reviews all deaths of individuals with a developmental disability reported to DBHDS incident	Submitted were the following documents entitled: 'Investigations: Appendix A: investigative Procedures, effective 1/1/20, revised for Connect August 2022; 'Investigations: Appendix C: DD Death Investigations' Revised for Connect August 2022.	19th X 21st X		This study verified that DBHDS achieved the requirements for this Compliance Indicator of 33.6. The submitted document entitled: 'DOJ MRC Table of Requested Info 8/1/21 through 7/31/22' provided this data which was reviewed. See ATTACHMENT 7 for details.

	reporting system				
33.7	Initial review within 24 hrs. of death reported to DBHDS or next business day	Submitted was a document entitled In the document 'Investigations: Appendix C: DD Death Investigations' Revised for Connect August 2022. The text includes a statement : Incident Management System (IMU) triages all DD Death Serious Incident (DSI) reports within 1 business day via the Connect system." Additionally, it states "D Death Investigations triaged in the Connect system will display in the SIU Share Work Queue. SIU Investigators will review the SIU Shared Work Queue daily…"	19th X 21st 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 33.7 during the 19th 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 CIs. See ATTACHMENT #7 for data for this CI.
33.8	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	In the submitted document: 'Investigations: Appendix C: DD Death Investigations', there is guidance concerning this area. All deaths are triaged within 1 business day. Then : "If during an investigation the investigator discovers possible health and safety violations that could affect the remaining individuals receiving service at the location, the investigator will review a larger sample of individual and/ or employee records and incorporate those findings into the investigation and along with any applicable licensing report issued."	19th X 21st 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 33.8 during the 21st 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. See ATTACHMENT 8 for confirmatory data.
33.9	Licensing provides	In the submitted document 'Investigations:	19th X		This study verified that DBHDS achieved the requirements for this

	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	Appendix C: DD Death Investigations' Revised for Connect August 2022, the following information addressed timeliness of the investigation report: "The Licensing Investigations Team provides available records and information it obtains and the completed investigation report to the MRC within 45 business days of the date of the death. Per DOJ indicator, this shall occur for at least 86% of deaths required to be reviewed by the MRC…Investigators will ensure that investigations are completed within 45 business days of the date the death occurred and the SIU manager completes the Master Document Posting Schedule(MDPS) to indicate date completed investigation was placed in MRC folder. MRC will report on meeting this indicator. "	21st X		Compliance Indicator of 33.9. The MRC Master Document Posting Schedule (MDPS) provided this data which was reviewed. See ATTACHMENT 9 for details.
C1#	Compliance Indicator Requirement	Evidence om DBHDS's submitted documentation	Status MET	Status NOT MET	Factual verification and analysis
33.10 a.	MRC process in identifying deaths subject to review				
	Incident reporting system queried monthly to extract reports of all deaths with	Submitted was a document entitled: 'Mortality Review Office/Mortality Review Committee Process and Procedure Document. ´ (revised August 2021). This document provides	19th X 21st X		This study verified that DBHDS achieved the requirements for this Compliance Indicator of 33.10a. See ATTACHMENT 10.

	an ID/DD dx receiving licensed ID/DD service and /or residing in training center	the detailed process by which all deaths with an ID/DD dx are tracked. "For licensed DD providers, the SIU Manager runs report DW-0080a weekly and forwards results to the Mortality Review Office Program Coordinator… 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. 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."			
a.	Extracted reports included in	All the above reports are added to the MDPS for tracking purposes	19th X 21st X		This study verified that DBHDS achieved the requirements for this Compliance Indicator of 33.10a.

	data tracking log for MRC review				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	Excerpts from 'Mortality Review Office/Mortality Review Committee Process and Procedure Document rev Aug 2021: " 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(s) may also be determined to be an unexpected death). 3. Abuse or neglect is specifically documented. 4. documentation of	19th X 21st 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 413 mortalities reviewed at the MRC meetings from August 2021 through July 2022, there were 413 electronic Mortality Review Forms (eMRF) completed. See ATTACHMENT 11a. The CCO or MRT Clinical Manager reviews the eMRFs and determines the Tier category for each death and this information is placed on the MRC agenda for the upcoming MRC meeting. The DBHDS MRC Meeting Minutes Attachment provide evidence that each death reviewed by the MRC is categorized as Tier 1 or Tier 2. See Attachment 11b.

		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 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 (including forensic) , is cited, 4. no documentation of specific or well defined risk to safety and well-being are noted." A fifth statement provides further guidance: "An expected death that occurred as a result of a known medical condition, anticipated by health care providers to occur as a result of that condition and for which there is no indication that the individual was not receiving appropriate care. 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."			
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 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..	19th X 21st X		This study verified that DBHDS achieved the requirements for this Compliance Indicator of 33.12, based on data from the submitted documentation July 2021 through June 2022. Information was located in the document: 'Potential Unreported Deaths Log' for each month reviewed. See Attachment 12a.
33.12	DBHDS Office of Licensing investigates all unreported deaths identified by this process	"The SIU team investigates all unreported deaths identified by this process and takes appropriate action in accordance with DBHDS licensing regulations and protocols.	19th X 21st X		This study verified that DBHDS achieved the requirements for this Compliance Indicator of 33.12. see Attachment 12b for details of OL review for those identified unreported deaths..
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	19th X 21st X		This study verified that DBHDS achieved the requirements for this Compliance Indicator of 33.12 . See ATTACHMENT 12c for details of the identified unreported deaths.

		DBHDS through the incident report system."			
C1#	Compliance Indicator Requirement	Evidence in DBHDS's submitted documentation	Status MET	Status NOT MET	Factual verification and analysis
	MRC process consistent with charter				
33.13	86% of unexplained/ unexpected deaths reported through DBHDS incident reporting system have a completed MRC review within 90 days of death.	See ATTACHMENT 13 for the statement in the MRC Charter.		19th X 21st X	This study **verified that DBHDS did not achieve** the requirements for this Compliance Indicator of 33.13. See ATTACHMENT 13 (Table A) for compliance of Unexpected deaths and All deaths to be reviewed within 90 days of death. Compliance for review (August 2021-July 2022) of unexpected deaths within 90 days was 52%. Review of all deaths (August 2021 - July 2022) within 90 days was 48.4% Compliance for five of the six months available for the 21st Review Period April-August 2022): Unexpected deaths: 75/98=76.5% All deaths: 156/196=79.6%. See TABLE 2A in ATTACHMENT 13.
33.14	Availability of specific key documents or documentation of unavailability of medical records	See ATTACHMENT 13 for the statement in the MRC Charter.	19th X 21st X		This study verified that DBHDS did achieve the requirements for this Compliance Indicator of 33.14a. This information was obtained from review of the electronic Mortality Review Forms completed for the individuals presented to the MRC from August 2021 through July 2022, as well as the MRC meeting minutes from the same time period. See ATTACHMENT 13 Table B, C, and D. If reports were not available, this was documented in the eMRF.

a.	Availability of physician case notes, nurses notes, incident reports for 3 months preceding death	See above quote from the 'Draft revised FY22 Mortality Review Charter.'	19th X 21st X		This study verified that DBHDS did achieve the requirements for this Compliance Indicator of 33.14a. This information was obtained from review of the electronic Mortality Review Forms completed for the individuals presented to the MRC from August 2021 through July 2022, as well as the MRC meeting minutes from the same time period. Progress notes were available for 99.5% of reviews, medical records were available for 86.5% of reviews. See ATTACHMENT 13 Table B. CHRIS serious injury reports were available for 100% of reviews. See Attachment 13 Table C. If reports were not available, this was documented in the eMRF.
a.	Availability or not of most recent individualized program plan	See above quote from the 'Draft revised FY22 Mortality Review Charter.'	19th X 21st X		This study verified that DBHDS achieved the requirements for this sub Compliance Indicator of 33.14a. See ATTACHMENT 13. Table B. ISPs were available for 99.8% of reviews. If reports were not available, this was documented in the eMRF.
a.	Availability of physical exam records	See above quote from the 'Draft revised FY22 Mortality Review Charter.'	19th X 21st X		This study verified that DBHDS achieved the requirements for this sub Compliance Indicator of 33.14. See ATTACHMENT 13. Table B. Annual physical exams were available for 58.6% of reviews If reports were not available, this was documented in the eMRF.
a.	Availability of death certificate and autopsy	See above quote from the 'Draft revised FY22 Mortality Review Charter.'	19th X 21st X		This study verified that DBHDS achieved the requirements for this sub Compliance Indicator of 33.14a. See ATTACHMENT 13. Table C.

	report (if applicable)				Death certificates were available for 94.6% of reviews. If reports were not available, this was documented in the eMRF.
a.	Any evidence of maltreatment related to death	See above quote from the 'Draft revised FY22 Mortality Review Charter.'	19th X 21st X		This study verified that DBHDS achieved the requirements for this sub Compliance Indicator of 33.14a. See ATTACHMENT 13 Table C. It was noted that the eMRF appeared to include a history of all recorded complaints of maltreatment (not just related to the death), a total of 66 reports, including those that were confirmed as well as those that were not confirmed.
b.	Interviews as warranted for any person(s) having information regarding individual's care		19th X 21st X		This study verified that DBHDS achieved the requirements for this sub Compliance Indicator of 33.14b. See ATTACHMENT 13. Table D. Interviews were completed for 9% of reviews.
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."		19th X 21st X	This study verified that DBHDS did **not** achieve the requirements for this sub Compliance Indicator of 33.15. Submitted Documents used in verification included : Quarterly reports: 'MRC Quarterly Report to the Commissioner December 7, 2021: A report on Deliberations and Findings During Quarter 1 of State Fiscal Year 2022', 'MRC Quarterly Report to the Commissioner: A Report on Deliberations and Findings During Quarter 2 of State Fiscal Year 2022.' 'MRC Quarterly Report to the Commissioner: A Report on

					Deliberations and Findings During Quarter 3 of State Fiscal Year 2022, ' and 'MRC Quarterly Report to the Commissioner: A Report on Deliberations and Findings During Quarter 4 of State Fiscal Year 2021.' In these documents, DBHDS did not meet requirements of this sub Compliance Indicator with reporting 86% of deaths requiring review within 90 days of death. See ATTACHMENT 14
33.15	When MRC makes no recommendations, this is stated, that no recommendations were warranted	The Mortality Review Committee Charter Draft revised FY22 states: "If the MRC elected not to make any recommendations, documentation will affirmatively state that no recommendations were warranted."	19th X 21st X		This study verified that DBHDS achieved the requirements for this sub Compliance Indicator of 33.15. For each MRC meeting, a 'DBHDS MRC Meeting Notes 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 contents (See ATTACHMENT 15 for quoted statements and the Curative Action quoted statements.)	19th X 21st X		This study verified that DBHDS achieved the requirements for this Compliance Indicator of 33.16. The following documents were reviewed for this Compliance Indicator: Virginia DBHDS SFY 2021 Annual Mortality Report, MRC Quarterly Reports to Commissioner, MRC Action Tracking LOG FY22/FY 23, MRC Quarterly Data Reports (Q4 FY21, Q1-3 FY22), the MRC Notes Summaries for each MRC meeting, and the eMRFs for the deaths reviewed at each MRC. See ATTACHMENT 15 for Curative Action #7 review of the additional definitions to be used concerning the level of prevention (primary, secondary, tertiary) for each of the deaths considered potentially preventable. From Jan -July 2022, all deaths determined by the MRC to be potentially preventable did include defining one or more prevention

					levels, documenting this additional parameter in the MRC minutes and or e MRF.
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				
33.17	Completed within 6 months of end of fiscal or calendar year	The Draft revised FY22 Mortality Charter states: " The MRC prepares an annual report of aggregate mortality trends and patterns for all individual deaths that occurred in the state fiscal year and that were also reviewed by the MRC, within 6 months of the end of the fiscal year. A summary of the findings is release publicly."	19th X 21st X		This study verified that DBHDS achieved the requirements for this Compliance Indicator of 33.17. The 'Virginia DBHDS SFY 2021 Annual Mortality Report' title page indicated it was completed December 2021. The 'Virginia DBHDS SFY 2021 Annual Mortality Report' was posted for public access on the DBHDS website 12/30/21 at 11:32:02 hr. (evidence was email from DBHDS IT confirming this date for the MRC SFY 21 Annual Report.)
	The annual report will , at a minimum include:				
i.	# and cause of deaths	'Virginia DBHDS SFY 2021 Annual Mortality Report' includes this information	19th X 21st X		This study verified that DBHDS achieved the requirements for this sub-Indicator 33.17i. See ATTACHMENT 16 for evidence in Virginia DBHDS SFY 2021 Annual Mortality Report
ii.	Crude mortality rate	Same as above	19th X 21st X		This study verified that DBHDS achieved the requirements for this sub-Indicator of 33.17ii See ATTACHMENT 16.
iii.	Crude mortality by residential settings	Same as above	19th X 21st X		This study verified that DBHDS achieved the requirements for this sub-Indicator of 33.17iii. See ATTACHMENT 16.
iv.	Crude mortality	Same as above	19th X		This study verified that DBHDS achieved the requirements for this

	rate by age		21st X		sub-Indicator of 33.17iv. See ATTACHMENT 16.
iv.	Crude mortality rate by gender	Same as above	19th X 21st X		This study verified that DBHDS achieved the requirements for this sub-Indicator of 33.17iv. See ATTACHMENT 16.
iv.	Crude mortality rate by race	Same as above	19th X 21st X		This study verified that DBHDS achieved the requirements for this sub-Indicator of 33.17iv. See ATTACHMENT 16.
v.	Analysis of patterns of mortality:				
v.	By age	Virginia DBHDS SFY 2021 Annual Mortality Report includes this information	19th X 21st X		This study verified that DBHDS achieved the requirements for this sub-Indicator of 33.17v. See ATTACHMENT 16.
v.	By gender	Same as above	19th X 21st X		This study verified that DBHDS achieved the requirements for this sub-Indicator of 33.17v. See ATTACHMENT 16.
v.	By race	Same as above	19th X 21st X		This study verified that DBHDS achieved the requirements for this sub-Indicator of 33.17v. See ATTACHMENT 16.
v.	By residential settings and DBHDS facilities	Same as above	19th X 21st X		This study verified that DBHDS achieved the requirements for this sub-Indicator of 33.17v. See ATTACHMENT 16.
v.	By service program	Same as above	19th X 21st X		This study verified that DBHDS achieved the requirements for this sub-Indicator of 33.17v. See ATTACHMENT 16.
v.	By cause of death	Same as above	19th X 21st X		This study verified that DBHDS achieved the requirements for this sub-Indicator of 33.17v. See ATTACHMENT 16.
b.	Summary of findings released publicly	This was confirmed in an email submitted as documentation for this indicator.	19th X 21st X		From email concerning 'MRC SFY Annual Report 2021' Date of release: 12/30/21 posted to DBHDS website: https://dbhdsqa.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 Annual Mortality Report 12.22.21 Final' includes a section on 'Recommendations'. In this section the following is stated: "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. 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 at least four recommendations annually for systemic quality improvement initiatives, and reports these recommendations to the QIC and the DBHDS Commissioner." Under the 'Background' section it also states: "The DBHDS DD MRC provides ongoing monitoring and data analysis in order to identify trends, patterns and issues of concern at	19th X 21st X		This study verified that DBHDS achieved the requirements for this Compliance Indicator of 33.18. See ATTACHMENT 17.

		the individual and systems levels of provided services. Once identified, and in order to reduce mortality rates to the fullest extent practicable, the DBHDS DD MRC develops and implements quality improvement initiatives (QII) in order to promote the health, safety and well-being of I/DD individuals."			
33.19	MRC makes 4 recommendations for systemic QI initiatives based on aggregate patterns or trends annually	MRC recommendations are located in the SFY 2021 Annual Mortality Report. This annual document included 6 recommendations from the MRC.	19th X 21st X		This study verified that DBHDS achieved the requirements for this Compliance Indicator of 33.19. See ATTACHMENT 17.
33.19	MRC reports these recommendations to the QIC and the DBHDS Commissioner	See excerpt from CI # 33.18. Submitted documents reviewed for compliance of this indicator included: 'MRC Quality Improvement Initiatives July 1, 2021 through June 30, 2022' (which includes more recent information on ongoing recommendations and initiatives beyond the Annual Mortality Report for SFY 2021.) The following MRC Quarterly Reports to the Commissioner includes recommendations and updates/progress data at the time of the quarterly report, as well as proposed	19th X 21st X		This study verified that DBHDS achieved the requirements for this Compliance Indicator of 33.19. See ATTACHMENTs 17.

		recommendations that were to subsequently be reviewed by the QIC. 'MRC Quarterly Report to the Commissioner: Q4 FY21 Q1 FY22, Q2 FY22, Q3 FY22.			
33.20	DBHDS develops and implements QI initiatives, either regionally or statewide, as recommended by MRC and approved by DBHDS Commissioner	See above 33.19	19th X 21st X		This study verified that DBHDS achieved the requirements for this Compliance Indicator of 33.20. See ATTACHMENTs 14, 17
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 2021, MRC Data Report Q1 2022, MRC Data Report Q2 2022, MRC Data Report Q3 2022.	19th X 21st X		This study verified that DBHDS achieved the requirements for this Compliance Indicator of 33.20. See ATTACHMENT 18 for QII content of the MRC Quarterly Data Reports.
33.20	MRC tracks implementation of QI initiatives	The MRC Data Report discussions are reflected in the approved minutes.	19th X 21st X		This study verified that DBHDS achieved the requirements for this Compliance Indicator of 33.20. See ATTACHMENT 18 for dates of MRC meetings discussing MRC Data Reports..
33.21	DBHDS disseminates the Quality Management Annual Report to stakeholders	Submitted was the "Developmental Disabilities Quality Management Plan State Fiscal Year 2021" dated May 16, 2022.	19th X 21st X		This study verified that DBHDS achieved the requirements for this Compliance Indicator of 33.21. The time and date on the website was 5/20/22 at 3:09:41PM confirmed by IT (per H. Norton)
33.21	Quality Management Annual	Submitted was the 'DBHDS Developmental Disabilities Quality	19th X 21st X		This study verified that DBHDS achieved the requirements for this Compliance Indicator of 33.21. See

	Report contains information related to QI initiatives, including any alerts or identified resources that promote QI consistent with indicator 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")	Management Plan FY 2021 May 16, 2022"			ATTACHMENT 19.
36.1	Curative Action compliance: Process Document completed	Data Set Attestations were submitted for CI #33.9 and #33.13. Content included the data set reviewed (MDPS), the MRO/MRC process and Procedure, the review by the Accountable	19th X 21st X		This study verified that DBHDS achieved the requirements for Compliance Indicator 36.1 concerning the mortality review process. Data Set Attestation Forms for #33.9 and #33.13 were completed and included the data set reviewed, the review for

		Executive, the Data Analyst review summary, and Chief Data Officer review summary and attestation signature.			completeness and representative of the data intended to be collected, the MRO/MRC process/procedure and steps taken by the Data Analyst to ensure reliability and validity of content. See ATTACHMENT 20.
	Attestation document signed.	Data Set Attestation Forms for #33.9 and #33.13 included the signature of the Chief Information Officer.	19th X 21st X		Data Set Attestation Forms for #33.9 and #33.13 were completed and signed by the Chief Information Officer 8/9/22, attesting to reliability and validity of the data.
	Primary Document Review of sample of individuals		19th X 21st X		See ATTACHMENT 20 for details. 24 individuals from Tier 1 were selected to spot check the verification of data; one was selected for each MRC meeting from August 2021 through July 2022. Agreement with reliability and validity was 96.7%.

PART II

Virginia DBHDS MRC 21st Review Period

Summary Bullets for the review of DBHDS MRC process

Advances

The 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 continues to reflect an expanded membership and a robust multidisciplinary approach.

Both Chair and Co-Chair of the MRC have clinical qualifications backgrounds.

An independent medical practitioner continues to participate in the MRC.

Database management continues to ensure the integrity and completeness of the data.

DBHDS has a system in place to capture unreported deaths.

A standardized format for the DBHDS mortality reviews continues to be utilized in providing essential information during MRC meetings.

Data collection reflects accuracy and completeness.

Timely monitoring of deaths and maintaining an 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 meetings.

The Special Investigations Unit (SIU)of the Office of Licensing continues to provide information to the MRC which allows for more accurate categorization of deaths as Expected/Unexpected, potentially preventable, and determinations of the causes of deaths. As a result, for the SFY reviewed, the MRC categorizes a reduced number of cases as having an unknown cause of death and there is increased clarity regarding whether maltreatment was a concern.

The Curative Action definitions were incorporated into the MRC process beginning January 2022.

With additional information, including that provided by the SIU, the MRC utilizes more complete and accurate information and appropriately applied the criteria in the Curative Action to categorize deaths as potentially preventable or not potentially preventable.

Starting with the January 2022 MRC meetings, for each of the deaths that the MRC categorized as potentially preventable (PP) deaths, the MRC also utilized the primary, secondary and tertiary prevention strategies specified in the associated Curative Action.

The MRC tracking system for pending information includes a monitoring process until data collection or recommendation implementation results in closure.

The MRC continues to utilize its ability to access death certificates and medical records from a variety of settings. With this additional information the data reviewed by the MRC has resulted in improved quality, consistency and completeness of its mortality reviews. The MRC categorized the factors that might have prevented the deaths. For each potentially preventable death, one or more categories were determined to be factors. Additionally, one or more prevention strategies were also determined applicable to each of the potentially preventable deaths.

Starting in March 2022, there was a positive trend toward the MRC reviews of unexpected deaths occurring within 90 days of the death.

Four or more recommendations have been made to the QIC for the year reviewed.

Once approved by the QIC, the MRC recommendations are implemented by DBHDS.

The MRC is updated at periodic intervals concerning the status of implementation of its recommendations.

The Annual Mortality Review Report included the components required by the Settlement Agreement.

The Annual Mortality Review Report was posted publicly in a timely manner.

Validation of reliability and validity of MRC reviewed data was confirmed by DBHDS and verified by a spot check with findings during this review.

Challenges:

The two causes of death that the MRC listed as 'complication of a congenital disease' and 'complications of a genetic condition' may obscure important trends in these sub-populations. Although these conditions may contribute to the category 'Expected Death', they are less helpful in determining the physiological cause of death, such as dysphagia, restrictive lung disease, acute choking death, bowel obstruction, aspiration pneumonia, sepsis, dementia, etc. Listing the cause of death with the event causing the pathophysiological decline would be more helpful in identifying trends and prevention strategy recommendations for these populations. It would also change the percentage of deaths caused by each category of death currently tracked.

During the past year, the MRC properly implemented the three levels of prevention to which it and DOJ agreed. Documenting in the MRC summary notes or eMRF the rationale for the choice of level of prevention (primary, secondary, and or tertiary) would assure consistency in making this determination over time for each of the potentially preventable deaths. This would allow sustained integrity of this data point and ensure consistent adherence to the criteria set forth by the Curative Action for V.C.5. Compliance Indicator 33.16.

Some of the deaths that were reviewed were due to cancer. However, whenever possible, it would be helpful to the MRC in determining trends and related recommendations to include the primary site of the cancer.

There remained a notable number of acute choking deaths.

Recommendations:

Heart disease and sudden cardiac death remained common causes of death in the reviewed population. The MRC should consider a future recommendation to reflect this concern. The MRC correctly noted that with increased data from health care sources, the number of individuals falling into the sudden cardiac death category had decreased, but heart disease remained an important cause of death.

Similarly, cancer deaths were significant, but no recommendation in the Annual Mortality Report looked at the potential causes or obstacles to cancer prevention.

For prior recommendations that were approved by QII and implemented, the Annual Mortality Report did not include a status report or a current review of findings. Including a brief update on the status of prior years' recommendations and quality improvement initiatives would be beneficial to stakeholders, especially those who live with and/or provide support to the members of the target population.

The 6/9/2022 MRC minutes indicated that up to 20 QIIs were ongoing. QIIs should be 1 year long, with determination at the end of the year whether the information collected was valuable, whether trend was possible but too brief a period of time, etc. It would be important to have MRC review these QIIS to determine which should be continued and which should be discontinued. The data collection process may also need to be reviewed. Some of the QIIs would benefit from long range trending with annual data collection. However, the data collection should be quickly available from a database and not consume staff time. Data collection processes for ongoing QIIs needs to be evaluated so they do not require MRC staff time.

Training of new staff did not initially appear to follow the timeline listed in the MRC Charter, but there was a process in place which was not well documented. Similarly, attendance at training updates with additional sessions as needed was also not well documented, but did occur for all participants. To give the MRC and MRT credit, and provide clear evidence of all training, an improved record keeping system is indicated for new MRC members within 30 days of participation, and updates for all members.

When a case is pended and brought back to the MRC at a future meeting, the eMRF table indicating documents is not updated or corrected to state that additional documents were received and reviewed.

It was noted that the discharge summaries provided by provider agencies varied greatly in content. To guide the provider agencies in reviewing expected essential information, a standardized template would create a consistent approach to documentation across provider agencies.

The percentage of MRC reviews within 90 days of death (both unexpected and all deaths) was approaching the 86% compliance indicator metric, but was not met during this review period. It is suggested that during the 22nd review period, an abbreviated independent review that is focused solely on the timeliness of death reviews be completed to determine compliance with this concern as well as reflecting this progress in the quarterly reports to the commissioner. In the meantime, it was noted there were several deaths that occurred in 2021 that had not yet been reviewed by the MRC. In order not to decrease the compliance percentage, it would be prudent to convene an MRC meeting which "catches up" all these incomplete reviews, so going into the 22nd review period , the percentage compliance within 90 days of death is no longer a challenge.

PART III

Virginia DBHDS MRC 21st Review Period

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, 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.

2021: 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.

For the above listed meeting minutes, the MRPF/eMRF reviews (Mortality Review Presentation Forms or electronic Mortality Review Forms) for individuals discussed at these meetings, MRC minutes included attendance documentation, agenda items, and the DBHDS Meeting Minutes Attachment/ MRC Meeting Notes Summary

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) August 2020-July 2021

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, Dec2019 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

MRC Quarterly Data Reports Q4 2020, Q1 2021 Final, Q2 2021 Final, Q3 2021 Final 5.27.21

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) through July 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 (SFY2021)

Monthly DW0080 (SFY2021)

PART IV

Virginia DBHDS MRC 21st Review Period

ATTACHMENT 2A (CI #33.1)

MRC membership of the MRC by role is listed as follows in the charter:

Required MRC members: Chief Clinical Officer, Assistant Commissioner of Developmental Services or designee, Assistant Commissioner for Compliance, Risk Management, and Audit or designee, Senior Director of Clinical Quality Management, Director Community Quality Management or designee, Director Office of Human Rights, or designee, Director Office of Integrated Health or designee, MRO Clinical Manager (MRC Co- Chair), OL Manager Incident Team, OL Manager Investigation Team, Office of Pharmacy Services Manager, MRO Clinical Reviewer, 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 from Department of Medical Assistance Services, Representative from Department of Health, Representative from Dept of Social Services, Representative from Office of Chief Medical Examiner, Representative from Community Services Board, other subject matter experts such as representatives from a DD Provider or Advocacy Organizations.

ATTACHMENT 2B (CI #33.1)

"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 is 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 cannot clearly be determined or established or is unknown. 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 medication condition(s) may also be determined to be an 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."

ATTACHMENT 2C (CI #33.1)

"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 compiles 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 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 record 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 is 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.

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 to promote safety, freedom from harm, and physical, mental , and behavioral health, and well-being, review OL corrective action plans related to required recommendations, to ensure no further action is required and 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."

ATTACHMENT 2D (CI #33.1)

"For each case reviewed, the MRC seeks to identify: the cause of death, if the death was expected, whether the 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, to include provider training and communication regarding risks, alerts, and opportunities for education ... make and document relevant recommendations and/or interventions. Documentation is located in the Meeting minutes, Notes Summary, 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 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. Cases that are pended are considered reviewed within 90 days of the individual's death based on the beginning review date. A pended case remains open until the following meeting, when the designated committee member provides an update, or specific information has been received, as requested. If all determinations are made, the pended case is closed by the committee."

ATTACHMENT 2E (CI #33.1)

"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."

ATTACHMENT 2F (CI #33.1)

"Members must recuse themselves from MRC proceedings if a conflict of interest arises, in order to maintain neutrality (prevent bias) 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 as:

The MRC member, or an individual from the member's family, was actively involved in the care of the decedent (direct care related to employment or financial as listed below); 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 (including determination and recommendations) 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 MRC 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 review of other cases, and then leave the proceedings prior to the discussion of the conflict of interest case."

ATTACHMENT 2G (CI #33.1)

"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 (s)he is permitted to attend.

Member confidentiality forms are 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."

Additionally: "All members adhere to agency policy and procedure related to HIPAA compliance and protecting confidentiality (DI 1001 – Privacy Policies and Procedures for the Us and Disclosure of PHI)."

ATTACHMENT 2H (CI #33.1)

"An unexpected death denotes a death that occurred as a result of a condition that was previous[y 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, inadequate care, or are associated with suspicions of

abuse or neglect. An acute medical event that was not anticipated in advance nor based on an individual's known medical condition (s) may also be determined to be an unexpected death."

ATTACHMENT 2 I(i) (CI #33.1h) This applies to both periodic review and analysis at individual service level and system level and documents the MRC role to develop and implement QII to reduce mortality rates.

"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.

Additionally, the MRC:

- Establishes performance measure indicators (PMIs) that align with the eight domains when applicable
- Monitors progress towards achievement of identified PMIs and for those falling below target, determines actions that are designed to raise the performance
- Assesses PMIs overall annually and based upon analysis, PMIs may be added, revised or retired in keeping with continuous quality improvement practices.
- Utilizes approved system for tracking PMIs, and the efficacy of preventive, corrective and improvement measures
- Develops and implements preventive, corrective and improvement measures where PMIs indicate health and safety concerns
- Share data or findings with quality subcommittees when significant patterns or trends are identified and as appropriate to the work of the subcommittee
- Utilizes data analysis to identify areas for improvement and monitor trends; identifies priorities and recommends QIIs as needed
- Implements approved QIIs within 90 days of the date of approval
- Monitors progress of approved QIIs assigned and addresses concerns/barriers as needed
- Evaluates the effectiveness of the approved QII for its intended purpose
- Demonstrates annually at least 3 ways in which data collection and analysis has been used to enhance outreach, education, or training
- Completes a committee performance evaluation annually that includes the accomplishments and barriers of the MRC"

Additionally: “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.”

ATTACHMENT 2J (CI 33.1h)

“The MRC documents recommendations for systemic QIIs coming from patterns of individual reviews on an ongoing basis, and analyzes patterns that emerge from any aggregate examination of mortality data for cases that were reviewed by the MRC on an ongoing basis.” “From this analysis, the MRC makes one recommendation per quarter for systemic QIIs, and reports these recommendations to the QIC (quarterly). “

ATTACHMENT 3 (CI #33.3.a-d)

According to the charter, confidentiality statements were to be obtained prior to attending any MRC meeting. Copies of confidentiality statements signed by participants were submitted.

Copies of signed confidentiality statements for all participants were submitted for this review. There was one participant for whom a signed confidentiality statement could not be found in the submitted documents for Review Period 21, but was found in submitted documentation for the Review Period 19. This participant was AH. A review of the archival process may be indicated to ensure all important documents are filed in an accessible location.

Additionally, there were two formal training sessions for updates on definitions used by the MRC and a new members/refresher training for MRC members. There were two submitted training documents submitted.

One was a power point presentation entitled “Mortality Review Committee Definition Updates December 2, 2021.” This was presented at the MRC of 12/2/21 and recorded in the Meeting Minutes of that MRC meeting. This was a training focused on changes / enhancements to definitions for Tier Categories, Expected and Unexpected Deaths, Potentially Preventable deaths, and three prevention strategies to be considered in recommendations.

The second training occurred on 7/28/22, through a power point presentation entitled :Mortality Review Committee Member Orientation.” Topics of this power point reviewed all the essential areas of orientation appropriate to the MRC, including the following topics: “Policies, Processes, and Procedures review, Role and Responsibilities of the Members, Definitions, Review of cause of death on Death Certificates.” Topics included purpose of the MRC, DBHDS and MRC mission, history of MRC development, MRC location in the DBHDS I/DD Quality Committee Structure/organizational plan, MRC charter review including components of purpose, scope, authority. membership, membership responsibilities, recusal, standard operating procedures, confidentiality procedures, MRC responsibilities and determinations and recommendations, quality assurance to ensure all deaths reported and reviewed, a list of

definitions used by the MRC, Tier status of all I/DD deaths, and guidance on understanding information on the death certificate. This was presented at the 7/28/22 MRC to both existing members as a refresher training, and for 3 new alternate members. These 3 alternates did not participate in the MRC meetings reviewed but were in preparation for the next state FY meeting cycle.

For both of these training presentations, submitted documentation did not include those not in attendance. At the conference call on 10/11/22, it was discussed that there were additional routes to providing the trained material. As an example, updated definitions were included in the most recent draft of the MRC charter, which was available to all participants. However, although the training and dissemination of information occurred, there was no formal record keeping documentation of these steps.

Training for new MRC participants was to be completed within 30 business days of joining the MRC. There were three new members to the MRC based on the date of the signed confidentiality statements.

KR joined the MRC as of 12/16/21. A confidentiality statement was signed 10/8/21. A focused MRC update training was provided on 12/2/21. Attendance was documented at the 7/28/22 Orientation MRC training.

EH joined the MRC as of 1/27/22. The confidentiality statement was signed 1/12/22. Attendance was verified at the orientation training of 7/28/22.

BA attended the MRC at least from 8/23/21, and perhaps earlier. A confidentiality statement was signed 7/30/21. There was verified attendance at the MRC update training on 12/2/21 and on 7/28/22 orientation training.

During the conference call, it was clarified that these participants attended training in a different format which included the Orientation MRC training, and the training occurred on the date the confidentiality statements were signed.

In summary, from the submitted documentation and the clarifications provided at the conference call on 10/11/22, the necessary training of new MRC participants occurred in a timely manner. It was pointed out that going forward, a more rigorous record keeping system is important to capture all training, in order to verify these activities. Additionally, when periodic update training is provided, a rigorous record keeping system is important to ensure all MRC members complete these requirements.

Three names on the participant list for the MRC did not attend any MRC meeting during the year and therefore no confidentiality statements or training requirements were indicated. These were for ZK, MC, and DN.

ATTACHMENT 4a (C1 #33.4)

This study verified that DBHDS achieved the requirements for Compliance Indicator #33.4. This determination was made based on a review of MRC meeting minutes and MRC Meeting Notes Summaries. There were two MRC meetings completed each month for a total of 24 meetings for the time period reviewed. Dates of MRC minutes and notes summaries:

8/12/21, 8/26/21, 9/9/21, 9/23/21, 10/14/21, 10/28/21, 11/4/21, 11/18/21, 12/2/21, 12/16/21, 1/13/22, 1/27/22, 2/10/22, 2/24/22, 3/10/22, 3/24/22, 4/14/22, 4/28/22, 5/12/22, 5/26/22, 6/9/22, 6/23/22, 7/14/22, and 7/28/22.

ATTACHMENT 4b (C1 #33.4)

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 20 members at each meeting, of which 10 to 17 were voting members, exceeding the minimal number required.

ATTACHMENT 5 (C1 #33.5)

This review verified that the 'Mortality Review Committee Action Tracking Log' identified recommendations from 8/12/21 - 7/28/22 and that the MRC tracked recommendations through closure.

Mortality Review Committee Action Tracking Log' is the source of the following information: The following lists the individuals needing follow up of recommendations during this time period, identified by their DBHDS ID#, and the number of recommendations made and completed:

#1797673 (3 of 3 recommendations completed), #314908 (1 of 1 recommendation completed), #1571135 (2 of 2 recommendations completed), #1 (2 of 2 recommendations completed), #626129 (2 of 2 recommendations completed), #32552 (2 of 2 recommendations completed), #447537 (1of 1 recommendation completed), #631749 (2 of 2 recommendations completed), #261576 (1 of 1 recommendation completed), #274298 (1 of 1 recommendation completed), #1777537 (2 of 2 recommendations completed), #588618 (1 of 1 recommendation completed), #1783368 (1 of 1 recommendation completed), #602254 (1 of 1 recommendation completed), #602113 (1 of 1 recommendation completed), #230578 (1 of 1 recommendation completed),

#363720 (2 of 2 recommendations completed), #350822 (2 of 2 recommendations completed), #55949 (2 of 2 recommendations completed), #707031 (1 of 1 recommendation completed), #545174 (1 of 1 recommendation completed), #577468 (2 of 2 recommendations completed), #151010 (1 of 1 recommendation completed), #1789625 (2 of 2 recommendations completed), #563794 (2 of 2 recommendations completed), #164069 (3 of 3 recommendations completed), #1607445 (1 of 1 recommendation completed), #194727 (1 of 1 recommendation completed), #575013 (3 of 3 recommendations completed), #682679 (3 of 3 recommendations completed), #1148923 (1 of 1 recommendation completed), #758112 (2 of 2 recommendations completed), #574133 (1 of 1 recommendation completed), #1364544 (1 of 1 recommendation completed), #350808 (1 of 2 recommendations completed), #188077 (1 of 1 recommendation completed), #457395 (1 of 1 recommendation completed), #229375 (1 of 1 recommendation completed), #1126068 (1 of 1 recommendation completed), #1704293 (2 of 2 recommendations completed.

There was only one outstanding recommendation still pending at the time of the submitted information, for # 350808, for an MRC meeting of 6/9/22.

The MRC Action Tracking Log included details of follow up with dates of follow up to completion. 28 individuals had recommendations for a death categorized as potentially preventable. 15 individuals had deaths not considered preventable, but had recommendations for follow-up of various aspects of care.

ATTACHMENT 6 (C1 #33.5)

MRC meeting minutes on the following dates included a narrative section providing updates of QI initiatives by the committee as well as quarterly data report updates concerning the QIIs:

The following MRC meeting minutes included information concerning QI initiatives:

At the 8/26/21 MRC meeting, The MRC was presented the Quarterly Data Report containing FY21 Q 4 data.

At the 10/28/21 MRC meeting, 4 potential proposed QIIs were presented to the MRC. These were: Substance Use Disorder/Narcan, Medication Management/Polypharmacy, TIBs related to Falls, AN Quality of Life and Comfort Care. These proposed QIIS were sent to members for review and feedback. The committee would need to consider what actions would be needed for the QII it chooses.

At the 11/4/21 MRC meeting, the MRC members discussed the 4 draft proposed Q2 QIIs to the QIC. It was determined that 3 potential QIIS were to be further developed and presented to the next MRC. One QII was tabled as it would be difficult to implement within 90 days.

At the 11/18/21 MRC meeting, it was recorded that the draft proposed Q2 QII was sent to members via email and requested feedback from members.

Also at the 11/18/21 MRC meeting, the FY 2022 Q1 Quarterly Data Report was presented to the MRC members.

At the 2/24/22 MRC meeting, the proposed Q3 QII was presented. The QII was to be reviewed and approved by the QIC. The proposed QII was approved by the MRC.

At the 3/10/22 MRC meeting, the FY 22 Quarterly Date Review was presented to committee members. Considerable discussion concerning this data was recorded in the minutes.

At the 5/26/22 MRC meeting, several potential QIIS were considered for Q4 QII. After considerable discussion, it was determined that a potential choking QII be developed and distributed to the committee for review.

At the 6/9/22 MRC meeting, the final draft of the choking PDSA/QII was approved, and was to be presented to the QIC. During a review of the Quarterly data report for Q2 of FY 22, the ongoing number of existing QIIs was also discussed, as there were potentially 20 ongoing QIIs at one time. There was discussion about collaboration with other committees completing reviews on similar topics. No action step was recorded.

At the 7/14/22 MRC meeting, it was discussed that the QIC did not approve the proposed choking QII related to capacity issues "as far as the MRC, as well as the RMRC's ongoing efforts surrounding choking."

In summary, QII data was presented on a quarterly basis. Also there was ongoing development of options for future QIIs with input from the various committee members throughout the year.

Attachment 7 (C1 #33.6)

A table was submitted entitled 'DOJ MRC Table of Requested Info 8/1/21 through 7/31/22" The data included the data of death of the individual, date filed in the DBHDS system and date the Incident Management Unit reviewed/triaged the report. There were 698 separate SIU investigations for approximately 416 deaths which occurred during the time period 8/1/21 through 7 /31/22 which was slightly different than the deaths reviewed at the MRC meetings from 8/2021 through 7/2022 (deaths would have occurred approximately 60-90 days prior to the MRC meeting date). As some individuals had more than one provider service, these deaths may have been reported more than once. In such cases, the earliest date entered into the DBHDS system was used to determine whether the death was reported within 24 hours. Additionally, some individuals had services stopped prior to death, and these were not counted as there was no regulatory requirement for reporting within 24 hours. Due to the complexity of the chart, the following numbers are approximate. There were approximately 416 deaths during the time period reflected in the chart, Of these, 84.4% were reported in the DBHDS system within 24 hrs. of the death. In discussion with the MRT and OL during a conference call 10/11/22, it was clarified that the Case Manager (CM) has 24 hr. from the time they are notified

of the death to report the death. There are circumstances in which non DBHDS licensed providers, nursing homes, rehab facilities have a death, but the CM, the only licensed service provider, is not notified within 24 hr. This would explain the majority of perceived delays in reporting a death within 24 hours to DBHDS. The breakdown of reporting in the DBHDS system greater than 24 hours was as follows:

August 2021 6 deaths, September 2021 3 deaths, October 2021 6 deaths, November 2021 7 deaths, December 2021 4 deaths, January 2022 11 deaths, February 2022 4 deaths, March 2022 5 deaths, April 2022 3 deaths, May 2022 3 deaths, June 2022 12 deaths, July 2022 1 death. It is noted that date of death may not always be the same as date of discovery of the death.

The 'DOJ MRC Table of Requested info 8.1.21 thru 7.31.22' confirmed that the initial review occurs by OL within 24 hrs. of death reported to DBHDS or next business day. This was confirmed for 414/416 (99.5%) of OL review dates. OL has a program in which triage occurs promptly with prompt referral to the SIU with SIU investigator assignment.

ATTACHMENT 8 (CI #33.8)

Two documents were submitted to verify this information. From "Information Requested for 21st DOJ MRC study OHR", 34 names were listed as having been identified with abuse/neglect concerns. A second table was submitted : "DOJ MRC Table of requested Info 8.1.21 thru 7.31.22" which provided dates of birth, date the provider reported the death, and date of triage. From this information, it could be determined 36 of 36 (100%) individuals identified as having abuse/neglect concerns had triage within one business day of the death being reported. The following table lists the timeline from when the death occurred to initial SIU triage. OHR cases that did not involve abuse/neglect were removed. The first business day was determined by removing weekend days and state holidays. Determination of timeliness was based on identifying confirmed cases, and in retrospect determining timeliness of initial response to these cases.

TIMELINESS OF SIU RESPONSE TO CONFIRMED ABUSE/NEGLECT CASES

	DBHDS#	Date of Death	Date Provider Reported	SIU Triage Date
1	55949	8/11/21	8/12/21	8/13/21
2	1607445	8/26/21	8/27/21	8/30/21
3	1580909	9/2/21	Not receiving services at time of death; 9/3/21	
4	621565	9/3/21	9/3/21	9/7/21
5	1579688	9/13/21	9/14/21	9/15/21
6	350822	9/20/21	9/21/21	9/22/21
7	758112	10/12/21	10/13/21	10/14/21
8	1797927 Case not yet reviewed at MRC	10/26/21	10/26/21	10/26/21
9	575481	10/27/21	10/27/21	10/28/21
10	577468	11/1/21	11/2/21	11/3/21
11	483233	11/8/21	11/8/21	11/9/21
12	483294	11/13/21	11/13/21	11/15/21
13	186	11/20/21	11/21/21	11/21/21
14	1789625	11/27/21	11/30/21	12/1/21
15	482829	12/9/21	12/10/21	12/13/21
16	164069	12/13/21	12/13/21	12/15/21
17	563794	12/18/21	12/18/21	12/20/21
18	162837	12/21/21	12/22/21	12/22/21
19	676013	12/28/21	12/28/21	12/29/21
20	682679	12/31/21	1/1/22	1/3/22
21	545539	1/9/22	1/9/22	1/10/22
22	118966	1/13/22	1/13/22	1/14/22
23	1366312	2/2/22	2/2/22	2/2/22
24	132698	2/8/22	2/8/22	2/9/22
25	662401	3/17/22	3/17/22	3/18/22
26	350808	3/20/22	3/21/22	3/22/22
27	339272	3/25/22	3/25/22	3/25/22
28	229375	3/30/22	3/31/22	4/1/22
29	634428	4/3/22	4/4/22	4/5/22
30	114278	4/12/22	4/13/22	4/13/22
31	1126068	4/13/22	4/14/22	4/15/22
32	1704293	4/16/22	4/19/22	4/20/22
33	222336	4/17/22	4/18/22	4/19/22
34	568383 (pending review at MRC)	5/2/22	5/2/22	5/3/22
35	608792 (pending review at MRC)	6/8/22	6/8/22	6/9/22
36	162860 (pending review at MRC)	6/12/22	6/13/22	6/14/22

ATTACHMENT 9 (CI #33.9)

MDPS month	# individuals listed (without discrepancy cases)	# individuals under OL regulatory review	OL report received within 45 business days from date of report
August 2021	41	40	39
September 2021	28	28	27
October 2021	38	37	37
November 2021	33	33	33
December 2021	30	30	30
January 2022	46	46	46
February 2022	35	35	35
March 2022	29	29	29
April 2022	30	29	29
May 2022	26	25	25
June 2022	43	43	43
July 2022	32	32	5, remainder pending
August 21-June 22		375	373 (99.4%)

ATTACHMENT 10 (CI#33.10)

From copies of emails, the following are the dates the MROPC received the monthly OL 80a report inquiries : 8/5/21, 9/7/21, 10/5/21, 11/9/21, 12/6/21, 1/6/22, 2/4/22, 3/7/22, 4/6/22, 5/2/22, 6/6/22, and 7/1/22.

Facility death queries were run on the following dates by DQV:

- 10/22/2021
- 11/3/2021
- 12/10/2021
- 12/13/2021
- 1/19/2022
- 2/11/2022
- 3/14/2022
- 4/19/2022
- 4/20/2022
- 5/3/2022
- 6/22/2022
- 7/20/2022

ATTACHMENT 11a (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 (pending cases are only counted in the initial MRC in which they were discussed):

8/12/21 MRC 29 eMRFs, 8/26/21 MRC 16 eMRFs, 9/9/21 MRC 15 eMRFs, 9/23/21 14 eMRFs, 10/14/21 MRC 16 eMRFs, 10/28/21 MRC 18 eMRFs, 11/4/21 MRC 8 eMRFs, 11/18/21 MRC 11 eMRFs, 12/2/21 MRC 9 eMRFs, 12/16/21 MRC 13eMRFs, 1/13/22 MRC 19 eMRFs, 1/27/22 11 eMRFs, 2/10/22 MRC 18 eMRFs, 2/24/22 MRC 19 eMRFs, 3/10/22 MRC 18 eMRFs, 3/24/22 22 eMRFs, 4/14/22 31 eMRFs, 4/28/22 MRC 26 e MRFs, 5/12/22 MRC 16 eMRFs, 5/26/22 MRC 17 eMRFs, 6/9/22 MRC 17 eMRFs, 6/23/22 MRC 17 eMRFs, 7/14/22 MRC 18 eMRFs, 7/28/22 MRC 15 eMRFs. All 413 eMRFs were reviewed for completeness and were found to have all components completed that were applicable to the death. This information was discussed at the time of the MRC.

ATTACHMENT 11b (C1#33.11

100% of the deaths were categorized at the MRC into Tier 1 or Tier 2. For Tier 1, numbers include the initial MRC date of review of a pended case. Although pended cases are subsequently resolved at follow up MRCs, they are not counted twice in the following information:

8/12/21 MRC 14 Tier 1 reviews & 15 Tier 2 reviews, 8/26/21 MRC 10 Tier 1 reviews & 6 Tier 2 reviews, 9/9/21 MRC 10 Tier 1 reviews & 5 Tier 2 reviews, 9/23/21 MRC 11 Tier 1 reviews & 3 Tier 2 reviews, 10/14/21MRC 5 Tier 1 reviews & 11 Tier 2 reviews, 10/28/21 MRC 8 Tier 1 reviews & 10 Tier 2 reviews, 11/4/21 MRC 6 Tier 1 reviews & 2 Tier 2 reviews, 11/18/21 MRC 7 Tier 1 reviews & 4 Tier 2 reviews, 12/2/21 MRC 5 Tier 1 reviews & 4 Tier 2 reviews, 12/16/21 MRC 7 Tier 1 reviews & 6 Tier 2 reviews, 1/13/22 MRC 8 Tier 1 reviews & 11 Tier 2 reviews, 1/27/22 MRC 5 Tier 1 reviews & 6 Tier 2 reviews. 2/10/22 MRC 11 Tier 1 reviews & 7 Tier 2 reviews, 2/24/22 MRC 10 Tier 1 reviews & 9 Tier 2 reviews, 3/10/22 MRC 5 Tier 1 reviews & 13 Tier 2 reviews, 3/24/22 MRC 16 Tier 1 reviews & 6 Tier 2 reviews, 4/14/22 MRC 12 Tier 1 reviews & 19 Tier 2 reviews, 4/28/22 MRC 16 Tier 1 reviews & 10 Tier 2 reviews, 5/12/22 MRC 6 Tier 1 reviews & 10 Tier 2 reviews, 5/26/22 MRC 8 Tier 1 reviews & 9 Tier 2 reviews, 6/9/22 MRC 5 Tier 1 reviews & 12 Tier 2 reviews, 6/23/22 MRC 11 Tier 1 reviews & 6 Tier 2 reviews, 7/14/22 MRC 12 Tier 1 reviews & 6 Tier 2 reviews, 7/28/22 MRC 7 Tier 1 reviews & 8 Tier 2 reviews..

ATTACHMENT 12a (C1#33.12)

The 'Potential Unreported Deaths' spreadsheet was submitted for July 2021 through June 2022.

The following records per month the number of potential cases that were researched and found not to be unreported deaths in the DBHDS system:

July 2021 – 8 cases. 4 of these were on the MDPS. 4 were confirmed to have no DBHDS licensed services at time of death. 2 were deactivated from the waitlist, 1 was on the waitlist, and 1 was released from waiver services.

August 2021 – 10 cases. 6 of these were on the MDPS. 4 were confirmed to have no DBHDS licensed services at time of death. 3 were on the waiver waitlist. 1 had been discharged from the waiver program.

September 2021 – 5 cases. 1 was in the MDPS. 1 was deactivated from the waitlist, , 1 was on waitlist. 1 1 not receiving licensed services, but other services not licensed by DBHDS, one was found to be not reported. Date of death was 9/8/21 and was reported 10/26/21. Documents were to be received by 10/29/21, an OL investigation was to be completed, and the Incident Management Unit was to issue a CAP for late reporting.

October 2021- 14 cases. 5 cases were in the MDPS. 1 was deactivated from the waitlist. 3 were released from waiver services, 5 were on the waitlist.

November 2021 – 0 cases. Confirmed by running 'DW-0096-DDVDH Death Records not in Chris Report'

December 2021 – 1 case who was deactivated from waitlist.

January 2022 – 0 cases. Confirmed by running 'DW-0096-DDVDH Death Records not in Chris Report'

February 2022 – 10 cases. 6 cases in the MDPS. 2 were on waitlist. 1 released from waiver services. 1 not notified of death until SIU manager contacted provider. Date of death 2/18/22, date reported 3/28/22. OL investigation was to be completed.

March 2022 – 1 case who was released from waiver.

April 2022 – 5 cases. 3 were in the MDPS. 1 was on waitlist. 1 was released from waiver services.

May 2022 – 12 cases. 4 were in the MDPS. 5 were on the waitlist. 1 was released from waiver services. 2 were deactivated from the waitlist.

June 2022 – 7 cases. 4 were in the MDPS. 2 were released from waiver services. 1 had no services at time of death.

ATTACHMENT 12b (C1#33.12)

For the one case (DBHDSID# 309378) found to be unreported in September 2021, with date of death 9/8/21, the eMRF was completed and death reviewed at the 7/14/22 MRC meeting. The OL investigation was posted 11/15/21.

For the one case (DBHDSID# 268742) found to be unreported in February 2022, with date of death 2/18/22, the eMRF was completed and death reviewed at the 5/12/22 MRC meeting. The OL investigation was posted 4/20/22.

ATTACHMENT 12c (C1#33.12)

For the one case (DBHDSID# 309378), the individual resided in a LTC facility. There was an APS report that was not related to a licensed provider. There was no OL CAP. The MRC did not find the death preventable.

For the one case (DBHDSID# 268742), the individual resided at the family home. There was no evidence of maltreatment and no OHR violation. There was an earlier CAP concerning the stopping of CM services, but no new CAP was issued by licensing.

ATTACHMENT 13 (Cl#33.13)

From the 'Draft revised FY22 Mortality Review Charter', the following are the relevant quoted statements for this section:

"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 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."

"The MRO then has four weeks after receipt of the OLI to compile a case review. Within 90 calendar days of a death, (and for any unreported deaths, as defined on page 6), the Mortality Review Team (MRT) compiles a review summary of the death. This includes development of succinct clinical case summaries (definition page 11) within two weeks of reviewing and documenting the availability or unavailability, of: ♦ Medical records: Including healthcare provider and nursing notes for three months preceding death ♦ Incident reports for three months preceding death ♦ Most recent individualized service program plan ♦ Medical and physical examination records ♦ Death certificate and autopsy report (when performed) ♦ Any evidence of maltreatment related to the death ♦ Interviewing, as warranted, any persons having information regarding the individual's care ♦ When additional documents are needed, the MRT

will request these records from appropriate entities per Virginia Code §§2.2-3705.5, 2.2-3711, and 2.2-4002 amendment of the Virginia Code"

Date for compliance of death review within 90 days of death

TABLE A

MRC date	Unexpected	Total Unexpected	Expected	Total Expected	U 90 day compliance	Total U comp	Expected and Unexpected compliance	All compliance cumulative
8/12/21	12	12	17	17	0		0	
8/26/21	4	16	12	29	0		0	
9/9/21	7	23	8	37	0		0	
9/23/21	6	29	8	45	0		0	
10/14/21	5	34	10	55	0		0	
10/28/21	10	44	8	63	0		0	
11/4/21	5	49	3	66	0		0	
11/18/21	8	57	3	69	0		0	
12/2/21	3	60	6	75	0		0	
12/16/21	4	64	9	84	2	2	5	5
1/13/22	10	74	9	93	1	3	2	7
1/27/22	4	78	7	100	1	4	3	10
2/10/22	5	83	13	113	4	8	12	22
2/24/22	6	89	12	125	5	13	13	35
3/10/22	6	95	12	137	5	18	15	50
3/24/22	9	104	13	150	9	27	22	72
4/14/22	19	123	12	162	14	41	23	95
4/28/22	22	145	4	166	17	58	21	116
5/12/22	9	154	7	173	8	68	14	130
5/26/22	8	162	9	182	7	75	14	144
6/9/22	7	169	10	192	7	82	15	159
i6/23/22	11	180	6	198	10	92	16	175
7/14/22	9	189	9	207	6	98	15	190
7/28/22	3	192	12	219	2	100	9	199

Compliance for unexpected: 100/192 =52%

Total cases unexpected and expected combined: 192+219=411 cases

Compliance for all cases combined: 199/411 =48.4%

Table A2 (Compliance calculations for 21st Review Period (April-August 2022)

MRC date 2022	Unexpected per MRC (a)	Total Unexpected (cumulative) (b)	Expected per MRC (c)	Total Expected (Cumulative) (d)	U 90 day compliance per MRC (e)	Total U completed timely (cumulative) (f)	Expected and Unexpected compliance per MRC (g)	Total cases reviewed per MRC (Unexpected and expected) (h)	Total cases Exp and Unex (cumulative) (i)	All compliance cumulative (j)
4/14	19	19	12	12	14	14	23	31	31	23
4/28	22	41	4	16	17	31	21	26	57	44
5/12	9	50	7	23	8	39	14	16	73	58
5/26	8	58	9	32	7	46	14	17	90	72
6/9	7	65	10	42	7	53	15	17	107	87
6/23	11	76	6	48	10	63	16	17	124	103
7/14	9	85	9	57	6	69	15	18	142	118
7/28	3	88	12	69	2	71	9	15	157	127
8/11	7	95	13	82	3	74	14	20	177	141
8/25	3	98	16	98	1	75	15	19	196	156
		total		total		Compl total			total	Compl total

Compliance for 21st review period April-August 2022):

Unexpected deaths: (f/b) 75/98=76.5%

All deaths: (j/i) 156/196=79.6%

TABLE B

MRC document availability for review

MRC	#deaths prelim review	Progress notes			Medical records			PE			ISP		
		Y	N	NA	Y	N	NA	Y	N	NA	Y	N	NA
8/12/21	29	27	0	2	21	2	6	16	13	0	27	0	2
8/26/21	16	16	0	0	12	3	1	6	10	0	16	0	0
9/9/21	15	15	0	0	11	3	1	7	8	0	15	0	0
9/23/21	14	14	0	0	11	2	1	7	7	0	13	0	1
10/14/21	15	15	0	0	12	0	3	8	7	0	14	1	0
10/28/21	18	17	1	0	15	1	2	8	10	0	18	0	0
11/4/21	8	8	0	0	6	2	0	3	5	0	8	0	0
11/18/21	11	11	0	0	9	2	0	5	5	1	19	0	1
12/2/21	9	9	0	0	7	2	0	5	4	0	9	0	0
12/16/21	13	13	0	0	12	1	0	6	7	0	13	0	0
1/13/22	19	19	0	0	18	0	1	9	10	0	18	0	1
1/27/22	11	11	0	0	10	1	0	9	2	0	11	0	0
2/10/22	18	18	0	0	13	5	0	9	9	0	18	0	0
2/24/22	18	18	0	0	15	3	0	12	6	0	18	0	0
3/10/22	18	18	0	0	14	3	1	13	5	0	18	0	0
3/24/22	22	22	0	0	17	4	1	14	8	0	22	0	0
4/14/22	31	31	0	0	27	4	0	19	12	0	31	0	0
4/28/22	26	26	0	0	21	5	0	16	10	0	25	0	1
5/12/22	16	15	1	0	16	0	0	11	5	0	16	0	0
5/26/22	17	17	0	0	15	1	1	14	3	0	17	0	0
6/9/22	17	16	0	1	12	2	3	11	6	0	16	0	1
6/23/22	17	17	0	0	14	2	1	12	5	0	17	0	0
7/14/22	18	18	0	0	15	2	1	8	10	0	18	0	0
7/28/22	15	15	0	0	13	2	0	13	2	0	15	0	0
total	411	406	2	3	336	52	23	241	169	1	403	1	7

Progress notes: applicable 411-3NA= 408 applicable cases, 406/408=99.5%

Medical records: applicable 411-23NA=388 applicable cases, 336/388=86.5%

Annual PE available : applicable 411-1 NA =410 applicable cases, 241/410= 58.6%

ISP: applicable 411-7 NA= 404 applicable cases, 403/404=99.8%

TABLE C

MRC	#deaths prelim review	Death certificate			CHRIS Report			Licensing report			Hx mal-treatment report		
		Y	N	NA	Y	N	NA	Y	N	NA	Y	N	Cum maltx
8/12/21	29	28	1	0	27	0	2	27	0	2	3	26	3
8/26/21	16	16	0	0	16	0	0	16	0	0	3	13	6
9/9/21	15	15	1	0	15	0	0	15	0	0	2	13	8
9/23/21	14	14	0	0	13	0	1	13	0	1	0	14	8
10/14/21	15	12	3	0	15	0	0	15	0	0	1	14	9
10/28/21	18	18	0	0	18	0	0	18	0	0	1	17	10
11/4/21	8	7	1	0	8	0	0	8	0	0	2	6	12
11/18/21	11	11	0	0	11	0	0	11	0	0	3	8	15
12/2/21	9	8	0	0	9	0	0	9	0	0	0	9	15
12/16/21	13	13	0	0	13	0	0	13	0	0	2	11	17
1/13/22	19	17	2	0	18	0	1	18	0	1	1	18	18
1/27/22	11	11	0	0	11	0	0	11	0	0	4	7	22
2/10/22	18	17	1	0	18	0	0	18	0	0	1	17	23
2/24/22	18	17	1	0	18	0	0	18	0	0	3	15	26
3/10/22	18	17	1	0	18	0	0	18	0	0	2	16	28
3/24/22	22	19	3	0	22	0	0	22	0	0	8	14	36
4/14/22	31	28	3	0	31	0	0	30	1	0	2	29	38
4/28/22	26	26	0	0	26	0	0	25	0	1	8	18	46
5/12/22	16	13	3	0	16	0	0	16	0	0	1	15	47
5/26/22	17	17	0	0	17	0	0	17	0	0	3	14	50
6/9/22	17	16	1	0	16	0	1	16	0	1	4	13	54
6/23/22	17	17	0	0	17	0	0	17	0	0	3	14	57
7/14/22	18	18	0	0	18	0	0	17	0	1	4	14	61
7/28/22	15	14	1	0	15	0	0	15	0	0	5	10	66
total	411	389	22	0	406	0	5	403	1	7	66	345	

Death certificates available: 389/411=94.6%

CHRIS reports available: 411-5NA=406 applicable cases; 406/406 =100%

Licensing reports available: 411- 7 NA = 404 applicable cases; 403/404 =99.8%

TABLE D

MRC	#deaths prelim review	cu	interviews	Cumulative interviews
8/12/21	29	29	2	2
8/26/21	16	45	1	3
9/9/21	15	60	1	4
9/23/21	14	74	0	4
10/14/21	15	89	0	4
10/28/21	18	107	0	4
11/4/21	8	115	2	6
11/18/21	11	126	2	8
12/2/21	9	135	2	10
12/16/21	13	148	4	14
1/13/22	19	167	3	17
1/27/22	11	178	4	21
2/10/22	18	196	3	24
2/24/22	18	214	1	25
3/10/22	18	232	1	26
3/24/22	22	254	4	30
4/14/22	31	285	1	31
4/28/22	26	311	1	32
5/12/22	16	327	1	33
5/26/22	17	344	0	33
6/9/22	17	361	0	33
6/23/22	17	378	2	35
7/14/22	18	396	2	37
7/28/22	15	411	0	37
total		411		37

% of reviews with completed interviews: 9%

ATTACHMENT 14 (C1#33.15)

Quarterly reports sent to the Commissioner were submitted: 'MRC Quarterly Report to the Commissioner: A Report on Deliberations and Findings During Quarter 4 of State Fiscal Year 2021,' 'MRC Quarterly Report to the Commissioner December 7, 2021: A report on Deliberations and Findings During Quarter 1 of State Fiscal Year 2022', 'MRC Quarterly Report to the Commissioner: A Report on Deliberations and Findings During Quarter 2 of State Fiscal Year 2022,' and 'MRC Quarterly Report to the Commissioner: A Report on Deliberations and Findings During Quarter 3 of State Fiscal Year 2022, '

MRC Quarterly Report	Q4 Fy 2021	Q1 FY 2022	Q2	Q3
Date of death of reviewed cases	Jan-March 2021 (93)	March-May 2021 (91)	May-Sept 2021 (75)	Aug 2021-Jan 2022 (106)
Top Causes of death	COVID 19 (18), heart disease (11) cancer (6), complication of genetic condition (6), neurodegenerative disease (6), sepsis (6)	Cancer (12), heart disease (10), complications of congenital condition (8)	Heart disease (9), cancer (6), complications of congenital condition (60< acute respiratory failure (5), complications of genetic condition (5), pneumonia (5)	Cancer (11), Pneumonia (9), failure to thrive/slow decline (7), heart disease (7)
COVID 19 deaths	58 as of Aug 17, 2021	Pending	Updated 5 as of Feb 24, 2022	Updated 33 as of May 26, 2022
Unexpected deaths	56	35 (fewer than prior 2 quarters)	36	40
Potentially Preventable (PP)deaths	7	9 (7 were unexpected):	5	6
Causative factors for PP deaths:				
A. Coordination of care	4	2	2 (but 4 in Q3 report)*	6
B. Access to Care	3	2	1 (but 3 in Q3 report)*	3
C. Execution of Established Protocols	4	7	5 (but 6 in Q3 report)*	5
D. Assessment of Needs, Change in Status	5	4	1(but 5 in Q3 report)*	4
90-day compliance	**Noncompliance 30.1% of deaths reviewed during Q4 were within 90 days of death.**	**Noncompliance, 0% of deaths reviewed during Q1 reviewed were within 90 day deadline.**	**Noncompliance 6.7% (5/75) deaths reviewed during Q2 reviewed within 90 day deadline**	**Noncompliance. 70.1% of deaths (75/106) reviewed within 90 day deadline.**
MRC Attendance and quorum	compliance	Compliance	compliance	compliance
Licensing submission of all documents within 45 business days	100% compliance Q3 FY 21	97% Compliance FY 2021 Q4	96% Compliance FY22 Q1	96% compliance FY22 Q2
Recommendation for unexpected and (PP) deaths within 90 days of review	6 of 6 compliant	Compliance	3 of 3 compliant	4 of 4 compliant
QII status update				

911 procedure compliance goal >60%	79%	48%		
Death certificate availability goal >90%	96%	93%		
Q4 rec to QIC: COVID 19 tracking goal decrease to <10% in COVID deaths.	NA	Implemented Sept 2021	updated, listed steps completed, in process	Updated steps completed, in process
Q4 rec to QIC: SIS level – goal reduce crude mortality rate by 5/1000 death per year with SIS level 6		Implemented Sept 2021	Updated, in process	Updated, in process
MRC recommendations				
Health & Safety Alert		Pending completion for fluoxetine toxicity		
		Pending for Polypharmacy		
		Resource for substance use disorders pending		
		Include hx in ISP planning document		
Narcan use training		Trainings updated		
Provider specific rec	4/8/21:3 4/22/21:2 5/13/21:6 5/27/21:1 6/10/21:2 6/24/21:2	July 22, 2021:1 August 12, 2021:8 August 26, 2021:2 Sept 9, 2021:4 Sept 23, 2021: 1	Oct14,2021:2, Oct28,2021:3, Nov 4,2021:2, Nov 18,2021:1, Dec 2,2021:3 Dec 16,2021:2	1/13/22:2 1/27/22:2 2/10/22:1 2/24/22:2 3/10/22:6 3/24/22:6
QII approved		Frailty QII approved by QIC	Updated/ in process	Updated/ in process
QII approved			Opioid overdose approved at Dec 2021 QIC updated, in process	Updated/ in process
Q3 proposed medical Emergencies II to				Reviewed

QIC				
QII proposed and not approved by QIC				QII proposed MRC Choking proposed to QIC 6.27.22 not approved.
QII proposed - sepsis training	updated/training provided			

*Discrepancy discussed with the MRT at the conference call 10/11/22

ATTACHMENT 15 (CI#33.16) MRC Charter and Curative Actions

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 wellbeing. … the MRC seeks to identify the cause of death, if the death was expected, whether the 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...MRC will then make and document relevant recommendations and or interventions."

(at the systemic level):

"the MRC…utilizes data analysis to identify areas for improvement and monitor trends, identifies priorities and recommends QIIs as needed, implement approved QIIs within 90 days of the date of approval, monitors progress of approved QIIs assigned and addressed concerns/barriers as needed. Evaluates the effectiveness of the approved QII for its intended purpose. ..

The MRC will make recommendations (including but not limited to, QIIs), in order to reduce mortality rates to the fullest extent practicable."

Agreed-Upon Curative Actions
"• #7 Mortality Review – V.C.5 Indicator #11 (Compliance Indicator ("CI") 33.16)
V.C.5 Indicator #11, CI 33.16
Section V.C.5 requires the Commonwealth to "develop and implement quality improvement initiatives to reduce mortality rates to the fullest extent practicable."

The Commonwealth shall take the following curative actions:

• The MRC shall use the following definition of potentially preventable:
o Potentially Preventable (PP) Deaths denotes deaths in the opinion of the MRC that might have been prevented with reasonable valid intervention (e.g., medical, social, psychological, legal, educational). Deaths determined to be PP have identifiable actions or care measures that should have occurred or been utilized. If the individual was provided with known effective medical treatment or public health intervention and died despite this provision of evidenced based care, the death is not considered potentially preventable. When the MRC determines a death is PP, the committee categorizes factors that might have prevented the death. For a death to be determined PP, the actions and events evident in any information within the three months preceding the individual's death must be related to deficits in the timeliness or absence of, at least one of the following factors:
o Coordination and optimization of care
o Access to care, including delay in seeking treatment
o Execution of established protocols
o Assessment of, and response to, the individual's needs or change in status

• For actions recommended by the MRC, the MRC shall consider if one of the following prevention strategies may be utilized:
o Primary Prevention Strategies—Educational and changes to services designed to help prevent a condition or event from taking place that has been found to contribute to morbidity or mortality such as education on reducing falls
o Secondary Prevention Strategies—Focus on early detection and timely treatment of conditions or injuries to minimize harmful effects and prevent further morbidity or mortality such as interventions that support and promote cancer screening
o Tertiary Prevention Strategies—Optimization of the treatment and management of conditions or injuries such as ensuring access to evidence -based treatments

• A death may be determined to be potentially preventable regardless of whether the death is actionable by DBHDS or within the control of DBHDS.
• Deaths that occur in settings that are not licensed by DBHDS may be potentially preventable.
• Deaths that do not indicate a violation of a licensing standard may be potentially preventable.
• The Commonwealth shall revise its definition of potentially preventable deaths and the criteria it utilizes to determine which deaths are potentially preventable as needed in

order to comport with the terms listed here.

• The Commonwealth shall ensure that all MRC members are trained within three (3) months on these terms and how to apply them. After implementation of these strategies, an expert in mortality review analysis will evaluate whether the MRC is appropriately applying these definitions.

• These changes will be implemented beginning with deaths starting in FY 2022 and after 6 months upon implementing the above changes, an expert in mortality review, agreed to by the parties, will review the results from the MRC's review to evaluate whether the MRC is appropriately applying its criteria and categorizing deaths as potentially preventable. If the MRC is not accurately categorizing such deaths, the Commonwealth will provide additional education and training to the MRC members.

• The Commonwealth shall analyze information about potentially preventable deaths and shall use that information to develop related quality improvement initiatives to reduce mortality rates."

Potentially Preventable Death Reviews (January 2022 – July 2022)

MRC categorization of deficits – post implementation of Curative Action #7 Mortality Review

individual	#1	#2	#3	#4	#5	#6	#7	#8	#9	#10	#11	#12	#13	#14
MRC date	1/13	1/27	2/24	3/10	3/24	3/24	4/14	4/14	4/28	4/28	6/9	6/9	6/23	7/14
Cause of death	TBI	choke	choke	choke	DM	pneu	trau	Trau	Asp pneu	choke	seiz	Heart dis	choke	Sepsis
Preventable factors:														
Coordinatn/ optimization of care		X		X	X	X							X	
Access to care, including delay in seeking tx	X				X	X	X				X	X	X	X
Execution of established protocols	X	X	X	X	X	X	X		X	X	X	X	X	X
Assessment of/response to individual's needs or COS	X	X		X	X	X		X			X	X		X
Levels of Prevention:														
Primary Prevention		X	X		X	X			X	X			X	
Secondary Prevention	X				X	X	X				X	X		X
Tertiary Prevention		X	X	X	X	X		X		X				

DBHDS ID# for:

#1 55949, #2 577468, #3 1789625, #4 563794, #5 676013, #6 682679, #7 1607445, #8 188077, #9 1364544, #10 758112, #11 457395, 12 #350808, #13 229375, #14 1704293.

Definitions of potentially preventable deaths were added the MRC Charter Draft FY22. As noted in the chart above, these deaths were categorized according to the four factors listed above (Coordination and optimization of care, access to care, including delay in seeking treatment, execution of established protocols, and assessment of, and response to, the individual's needs or change in status.)

In determining which prevention strategies to be utilized, the MRC did list at least one category for each potentially preventable death as primary, secondary, or tertiary, as required as a curative action.

ATTACHMENT 16 (C1#33.17i-v)

The SFY 21 MRC Annual Report included the following information:

i. Number and causes of death: This report documents 408 deaths (as noted in the Key Findings (and confirmed in Table 2 and Table 3), which is the number of individual deaths reviewed by DBHDS DD MRC, regardless of whether they were authorized to receive DD waiver services. Table 1 provides the annual deaths by cause of death for 2021. Leading causes of death were: COVID 19 (60 deaths), heart disease (37 deaths), cancer (33 deaths), sudden cardiac death (29 deaths), neurodegenerative diseases (21 deaths), sepsis (21 deaths), pneumonia (20 deaths), aspiration pneumonia (19 deaths). Complication of congenital condition (18 deaths), complication of genetic conditions (18 deaths), and seizures (16 deaths). There were several additional categories with lesser numbers of deaths assigned to each category.

ii. Crude mortality rate: This was documented under the narrative 'Population Demographics', as 26.8 deaths per 1,000. The crude mortality rate for individuals authorized to receive waiver services was 21.3 deaths per 1,000, as noted in Table 4. Table 5, and Table 6.

iii. Crude mortality rate by residential setting was provided in 'Table 8. Deaths by Residential Setting, SFY 2018-2021'. This data included deaths of those authorized for waiver services and those not authorized to receive waiver services, which included 408 individuals. Residential settings were listed as Congregate (179 deaths), Facility (14 deaths), Independent (157 deaths), Institution (35 deaths), and Unknown (23 deaths). Table 9. Crude Mortality Rates by DD Waiver Residential Setting per 1,000 population, SFY 2021' documents a crude mortality rate of 38.0 for congregate settings, and 11. 9 for Independent living settings. For the non-waiver

population, 'Table 10. Crude Mortality Rates by Non-Waiver Residential Setting per 1,000 population, SFY 2021,' documents the crude mortality rate for Facilities (30.6) and Institutional settings (8.6).

iv. Crude mortality rate by age was provided in 'Table 4. Crude Mortality Rates by age per 1,000 population SFY 2021' for 324 individuals authorized to receive DBDHS waiver services. For ages 31-80, deaths were categorized by decade of age. For those under 31, there were two categories, on age 0-17years, and the other 18-30 years. For those over age 80, there was one category of '81 and above'.
Crude mortality rate by gender was provided in 'Table 5. Crude Mortality Rates by Gender per 1.000 population, SFY 2021.' The narrative is opposite the information in Table 5. The crude mortality rate for females was 23.6 in Table 5, and 19.8 in the narrative. The crude mortality rate for males was 19.8 in Table 5, and 23.6 in the narrative. This appeared to be an editing error in the report. This was discussed with the MRT at the 10/11/22 conference call..
Crude mortality rate by race was provided in 'Table 6. Crude Mortality Rates by Race per 1,000 population, SFY 2021.' The crude mortality rate of the white/Caucasian population was lower than the crude mortality for the I/DD population authorized to receive waiver services. The crude mortality rate of the Black/African American population was higher than the crude mortality rate for the I/DD population authorized to receive waiver services.

v. Analysis of patterns of mortality

By age: The report identified that the 61-70 year age group had the most deaths of any decade. This trend had not changed in the prior 3 years. Compared to SFY 2020, the crude mortality rate increased for all age ranges except those age 30 and younger.

By gender: 'Figure 4. Crude Mortality Rates by Gender per 1,000 population SFY 2018-2021' demonstrated that the mortality rate for males increased 33% from SFY 2020, from 17.8 deaths per 1,000 population to 23.6 per 1,000 population . For females, there was improvement, with a crude mortality rate that decreased from 21.5 deaths per 1,000 in SFY 2020 to 19.8 deaths per 1,000 in SFY 2021.

By race: 'Figure 5. Crude Mortality Rates by Race per 1,000 population, SFY 2018-2021' documented a 3% decrease from 21.4 deaths per 1,000 population in SFY 2020 to 20.8 deaths per 1,000 population in SFY 2021.However, , the Black/African American population had a 30% increase in the crude mortality rate, from 18.1 deaths per 1,000 population in SFY 2020 to 23.6 deaths per 1,000 in SFY 2021.

By residential settings and DBHDS facilities: The trend analysis is quoted here: “In SFY 2021, the percentage of deaths among individuals in state facilities increased, which contrasts the decreasing trend established since SFY 2017. The percentage of deaths for congregate and independent residence are similar in SFY 2021 as the previous year. SFY 2021 institutional deaths decreased slightly compared to SFY 2020.” ‘Figure 7. Crude Mortality Rates by Residential Grouping per 1,000 population, SFY 2018-2021’ provides visual trend lines for data. Quoting from the report: In SFY 2021, the crude mortality rate among those living in congregate settings was 38 deaths per 1,000 population, a nine percent increase from 34.9 deaths per 1,000 population in SFY 2019. The crude mortality rate among those living independently increased from 10.2 deaths per 1,000 population in SFY 2019 to 11.9 deaths per 1,000 population in SFY 2020, a 17 percent increase. The crude mortality rate for both congregate and independent living are at their highest since 2017. Again, these congregate settings were particularly vulnerable to the impact of COVID-19.”

By service program: Quoting from the discussion following ‘Table 7. Crude Mortality Rates by SIS Level per 1,000 population, SFY 2020’: “ From SFY 2020 to 2021, the crude mortality rate increased for individuals on the DD waiver with SIS Levels 2, 4, 5 and 7 and decreased for those with SIS Levels of 1, 3and 6. In SFY 2021, the highest crude mortality rate on the waiver by SIS Level was for SIS Level 6, which captures the population of individuals with the highest level of intensive medical needs. However, the crude mortality rate among individuals with a SIS Level of 6 decreased to 59.5 deaths per 1,000 population in SFY 2021 compared to 76.2 deaths per 1,000 in SFY 2020. The most deaths occurred in individuals on DD waiver with SIS level 4, which serves individuals with moderate to high needs and is the SIS level that serves the highest number of individuals on a waiver. SFY 2021 SIS level 4 comprised of 145 deaths and a crude mortality rate of 25.0, which is increased 21 percent compared to SFY 2020 (20.4 deaths per 1,000). From SFY 2020to 2021, the crude mortality rate increased for individuals on the DD waiver with SIS Levels 2, 4, 5 and 7 and decreased for those with SIS Levels of 1, 3 and 6. In SFY 2021, the highest crude mortality rate on the waiver by SIS Level was for SIS Level 6, which captures the population of individuals with the highest level of intensive medical needs. However, the crude mortality rate among individuals with a SIS Level of 6 decreased to 59.5 deaths per 1,000 population in SFY 2021 compared to 76.2 deaths per 1,000 in SFY 2020. The most deaths occurred in individuals on DD waiver with SIS level 4, which serves individuals with moderate to high needs and is the SIS level that serves the highest number of individuals on a waiver. SFY 2021 SIS level 4 comprised of 145 deaths and a crude mortality rate of 25.0, which is increased 21 percent compared to SFY 2020 (20.4 deaths per 1,000).” Of note, Table 7 indicated it was data from

SFY 2020, but it was assumed this was a typographical error and meant SFY 2021. This was discussed with the MRT during the conference call 10/11/22.

By cause of death: 'Table 1. Number of Annual Deaths by Cause of Death, SFY 2018-2021' provides the data from which the narrative summarizes trend information. The Unknown cause of death decreased from 16 deaths in SFY 2020 to 2 deaths in SFY 2021. In SFY 2019, the unknown was the leading cause of death. COVID deaths started to occur in the 4th quarter of SFY 2020. SFY 2021 reflected the highest rate of transmission , with COVID 19 the number one cause of death for SFY 2021 (14.7%).

ATTACHMENT 17 (CI #33.18 and CI #33.19))

The following excerpts provide evidence that the 'SFY 2021 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: In the 2019 Annual Report, it was recommended that DBHDS should maintain an established target that potentially preventable deaths make up less than 15 percent of the total DD deaths per year. While there was an increase in the percentage of potentially preventable deaths in SFY 2021 from 5 percent (SFY20) to 10 percent, the MRC should continue to examine if the definition of potentially preventable needs revision, clarification, or updates, to better capture opportunities that may improve the rates of mortality in the I/DD population.

Recommendation 2: In SFY 2020, failure to adhere to established 911 protocol was identified by the DBHDS DD MRC as a major contributor to the potentially preventable factor of 'Execution of Established Protocols.' In SFY 2021, the DBHDS DD MRC began implementation of a quality improvement initiative to increase providers' adherence to protocols related to calling 911, as baseline data indicated that follow through with their own protocols in calling 911, was only followed for an average of 30 percent of deaths where calling 911 was a factor. In SFY 2021, the MRC collaborated with the Offices of Licensing and Provider Development to increase training and adherence to providers related to emergency response protocols. In SFY 2022, DBHDS should establish a metric to increase the number of mortality review cases in which 911 protocol was followed to greater than 60 percent.

Recommendation 3: In the 2019 Annual Report, it was recommended that DBHDS should maintain an established target of less than 10 percent 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 Committee, which provides greater access to information and records for an individual whose death is being reviewed by the Committee, from providers beyond those licensed by DBHDS. This legislation

went into effect on July 1, 2020, and has had a significant impact on the DBHDS DD MRC in determining the cause of death, with only two of 408 deaths determined to be cause of death as unknown. Determining the cause of death is a key factor in understanding and developing systemic quality improvement initiatives, and having access to pertinent information and records facilitates that determination. In SFY 2021, DBHDS received 98 percent of death certificates, achieving last year's quality improvement initiative's goal of over 90 percent. DBHDS should continue to monitor this on an annual basis to ensure that this trend is sustained over time.

Recommendation 4: As mentioned previously, COVID-19 continues to impact vulnerable I/DD individuals, and was the cause of death for 23 percent of unexpected deaths in SFY2021. For the next fiscal year, the MRC will measure COVID-19 mortality among the I/DD population to determine if a decrease to less than 10 percent is noted by raising awareness of the need for vaccines, maintaining infection control measures, and surveillance for COVID-19 symptoms in these at-risk individuals.

Recommendation 5: Death due to sepsis represented 5 percent of deaths in this study year compared to 11 percent of deaths in the year prior. 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 the development of sepsis or death. For SFY2021, DBHDS evaluated underlying causes and conditions that lead to an increase in sepsis deaths in this population, with the primary contributing cause as urinary tract infection(UTI). This information was shared with the DBHDS Risk Management Review Committee (RMRC), to examine interventions further upstream from the event resulting in mortality. The DD MRC should continue to monitor if interventions and quality improvement initiatives taken by the RMRC, will decrease rates of sepsis due to UTI.

Recommendation 6: The DD MRC should consider aligning the actions taken when a potentially preventable death is identified, with best practices in mortality prevention strategies to further understand the resources and activities that may achieve a greater impact on reducing mortality to the greatest extent practicable. These activities may include: identifying systemic actions and interventions to increase provider and individual education about disease and treatments, training, and up-to-date recommendations on best practice, and early identification of risk factors or illnesses that contribute to the top causes of deaths in the I/DD population."

Submitted was a document entitled 'MRC Quality Improvement Initiatives July 1, 2021 through June 30, 2022." This included a review of 'Proposed QIIs with QIC Approval/Disapproval' with brief descriptors of the QIC:

'Proposed Frailty QII' 9.27.21/ QIC Approved 9.27.21:

“BACKGROUND: Frailty may play a decisive role in increasing adverse health outcomes within the ID/DD population. In reflection of SFY21 case reviews, the MRC hypothesizes that frailty awareness and its role in health outcomes may be a predictor of mortality, particularly in individuals in SIS level 6. SIS assessments are used to determine the type of services and supports needed and MRC data indicates increased rates of mortality in SIS level 6 compared to other SIS levels. The MRC has identified a myriad of complex medical and behavioral conditions during case reviews and feels that use of a standardized and objective tool, such as a frailty assessment, may be needed to further predict mortality in this population. Assessment of a decedent’s needs or change in status is a major factor the MRC has attributed to potentially preventable deaths.

AIM: MRC goal by Q1 of SFY2023 is to collect baseline data for I/DD individuals in SIS level 6, that can inform if the use of a frailty tool could be used as a predictor of mortality. There is no frailty data available, statewide, as it is currently being utilized in only a minority of DBHDS Offices.”

‘Proposed Opioid Overdose QII’ 12.13.21/ QIC Approved 12.13.21:

“BACKGROUND: The ongoing pandemic impacted the availability and accessibility of supports, services and training, across the Commonwealth of Virginia. One result of this impact was seen in the increase in opioid overdose deaths. The number of fatal opioid related drug overdoses in the Commonwealth has sharply increased since 2012. From 2007-2015, opioids made up approximately 75% of all fatal drug overdoses annually in Virginia. In 2020, 83.0% of all fatal overdoses of any substance, were due to one or more opioids (including fentanyl). Fentanyl is a powerful synthetic opioid. Prior to 2013, most fentanyl-related deaths were due to illicit use of pharmaceutically produced fentanyl. However, in late 2013, law enforcement investigations and toxicology testing demonstrated an increase in illicitly produced fentanyl. By 2016, most fatal fentanyl-related overdoses were due to illicitly produced fentanyl and fentanyl analogs, and not pharmaceutically produced fentanyl. (For statistical purposes, ‘fentanyl’ includes all pharmaceutically produced fentanyl, illicitly produced fentanyl, and fentanyl analogs). The number of fatal fentanyl overdoses in 2020 compared to 2019 increased by 72.0%.In 2020, all fatal opioid overdoses increased 47.5% from the previous year. In SFY21, the IDD population saw a 2% increase in opioid overdose deaths compared to previous years of 0%. It is too soon to know if this is a true trend in the IDD population. The VA Board of Pharmacy requires that Naltrexone (Narcan) be prescribed and offered with every opioid prescription in Virginia. REVIVE! is the opioid overdose and Naloxone Education program for the Commonwealth of Virginia. REVIVE! provides training on how to recognize and respond to an opioid overdose emergency using naloxone. By increasing knowledge of substance use disorders (SUD), support for these high risk individuals and training in REVIVE! (community based opioid overdose emergency treatment), the MRC hopes to promote health and safety outcomes for individuals with I/DD with SUD and/or experiencing an opioid overdose. Additional information on fentanyl

can be found at https://www.drugabuse.gov/publications/drugfacts/fentanyl. AIM: MRC goal is increase the percentage of I/DD providers completing REVIVE! Training by SFY22 Q4 to 30%. There is no baseline data for the number of providers who have completed REVIVE! Training."

'Proposed Medical Emergencies II' 3.28.22/ QIC Approved 3.28.22:

BACKGROUND: Cases where DBHDS providers executed established 911/emergency preparedness protocols, have not risen above 63%. Delays in calling 911 at the first sign of a medical emergency have adverse effects on an I/DD individual's outcome. The "Importance of Calling 911" training has been posted to COVLC, which provides on-demand access for providers. On review of 911 audio tapes, many DBHDS provider staff cannot provide the following information to the 911 dispatcher: address of the residence, important medical information, and code status (DNR (appropriate/legal for hospital setting)/ DDNR (Durable DNR) (appropriate/legal for community setting)/DNI). At times, the provider staff member does not follow the dispatcher's instructions when instructions are provided; not all localities are certified to provide specific or detailed instructions during 911 calls. Having staff unable to provide crucial information such as noted above or not following the instructions provided by the dispatcher, also delays the provision of timely treatment. Currently, there are limited standards for what must be included in emergency management policies and procedures for DBHDS licensed providers: no standards for processes to track emergency preparedness training of DBHDS licensed providers and staff; and no requirements regarding medical emergencies and use of medical emergency scenario drills to train on handling/preparing for medical emergencies. Provider policies & procedures appear to be minimally meeting emergency preparedness requirements for I/DD individuals. The degree of provider training regarding emergencies and calling 911 and what is included within that training, is not fully known by DBHDS. What is known: training typically occurs at orientation and most do training annually. Literature on training and education techniques indicates that hands-on (kinesthetic or experiential) learning, in addition to traditional audio/visual learning, is more effective. People learn and retain information through actual performance via simulation, rather than being distanced from it through books, videos and/or classroom lectures. This also provides an environment for mistakes to be made safely, learning by trial and error, and practicing critical thinking and skill techniques safely, with no harm or blame. The OL SIU has submitted a request for revision of OL regulations to include medical emergency scenario drills; but the process of change will take 1-2 years or more. Currently, OL SIU staff provide OIH alerts and training information to providers when issuing citations and encourage providers to incorporate medical scenario drills into their policies and procedures.

AIM: The goal of the MRC is to increase the percentage of adherence to the execution of provider established protocols for medical emergencies to >70% for I/DD individuals residing in DBHDS licensed provider residences, by the end of SFY23 Q3. The baseline was 63% during SFY21."

‘Proposed MRC Choking QII 6.27.22/ QIC did not approve 6.27.22

“BACKGROUND: The MRC used team decision-making and 'Could-This-Be-A-QII' tool to determine that this QII is warranted. This QII is important as the data does shows an increase in the number of deaths caused by choking. It is also important as it a known risk that the MRC can impact. Since SFY2018, choking as a cause of death (CoD) has been on the rise for individuals receiving services from DBHDS licensed providers at the time of the death (SFY2018=0 deaths; SFY2019=2 deaths [0.64%]; SFY20=5 deaths [1.41%]; SFY2021=8 deaths [1.96%]). As of May 2022, the MRC determined 7 deaths were caused by choking. Choking is one of the twelve serious incidents that the Risk Management Review Committee monitors. The rate of choking incident per 1,000 individuals in the SFY21 Annual RMRC Report was 3.4 and in SFY20, it was 4.42. While the MRC has identified several potential causes, there is no data regarding the frequency of occurrences for these potential causes available.

AIM: Goal of the MRC -to decrease choking as CoD in I/DD individuals to less than eight by June 30, 2023 or sooner if possible. BASELINE: SFY2018=0 deaths; SFY2019=2 deaths (0.64%); SFY20=5 deaths (1.41%); SFY2021=8 deaths (1.96%). As of May 2022, the MRC determined 7 deaths were caused by choking. The rate of choking incident per 1,000 individuals in SFY21 was 3.4 and in SFY20, it was 4.42. There is no data regarding the frequency of occurrences for potential causes of choking available.

BARRIERS:1 -A significant barrier identified by the MRC is a major capacity issue for this QII. There are currently 5 QIIs (2 HSW & 3 PCC) already in progress for the next 12 months, that heavily involve staff from other DBHDS offices. 2 -Also of note, in order to accommodate the increased number of complex case reviews that must occur, MRC meeting times have consistently increased to 3.5 or 4 hours. This requires extensive prep from OL & MRO staff every other week. 3–OIH currently is contributing 32+ RN hours/week to assist with MRO clinical reviews for each MRC meeting.”

Abandoned-Completed QIIs

911 Protocol QII Approved 3/5/20 Abandoned 12/16/22 (did not achieve desired outcome)

Available Death Certificates QII Approved 6/30/20, completed/adopted 11/18/21

QIIs in Progress:

SIS level QII approved 6/28/21

COVID 19 Mortality approved 6/28/21

Frailty QII approved 9/27/21

Opioid Overdose QII approved 12/13/21

Medical Emergencies QII approved 3/8/22

ATTACHMENT 18 (CI#33.20)

The MRC Data Report Q4 2021 was discussed at the 8/26/21 MRC meeting.

The MRC Data Report Q1 2022 was discussed at the 11/18/21 MRC meeting.

The MRC Data Report Q2 2022 was discussed at the 3/10/22 MRC meeting.

The MRC Data Report Q3 2022 was discussed at the 6/9/22 MRC meeting.

The following Table reflects the content of the MRC Data Reports to the MRC concerning updates on various QII projects which were ongoing.

QII	MRC Data Report Q4 2021	MRC Data Report Q1 2022	MRC Data Report Q2 2022	MRC Data Report Q2 2022
911 QII	X	X		
Death Certificate QII	X	X		
Sepsis Training QII	X			
COVID 19 QII	X	X	X	X
SIS Level QII		X	X	X
Frailty QII		X	X	X
Opioid Overdose QII			X	X
Medical Emergencies QII				X
Choking QII				To be presented to QIC 6/27/22

ATTACHMENT 19 (CI #33.21)

Within the SFY21 DD QM Plan Final 5.16.22, was the purpose of the MRC:

"Mortality Review Committee (MRC) reviews and collects mortality data for intellectual and developmentally disabled (DD) individuals who received services from a DBHDS licensed provider at the time of their death. The committee's purpose is to identify and implement system wide QIIs to reduce the mortality rates for this targeted population to the fullest extent practicable. MRC conducts a trend analysis of mortality data to identify patterns at the individual service-delivery and system levels. The mortality review process enhances quality by providing information that triggers corrective action to reduce future risk and affords a retrospective examination regarding process, service level performance, and adherence to standards, to inform CQI."

The MRC Charter (QIC approved 9/27/21) was included.

Under the section "II. Key Accomplishments of the Quality Management Program", several accomplishments of the MRC were listed:

“Mortality Review Committee (MRC) published the SFY2020 Annual Mortality Report in December 2020, which included the analysis of 345 mortality reviews; 95.1 percent of the reviews were completed within 90 calendar days.

MRC expanded use of the electronic Mortality Review Form (eMRF) to track, record, and store data for identification of trends, patterns, service gaps, and data reporting

MRC engaged with the Center for Developmental Disabilities Evaluation and Research (CDDER)at the Shriver Center at the University of Massachusetts Medical School, to enhance MRC definitions and processes.

Through collaboration with the OL, the Data Warehouse(DW)and Virginia Department of Health (VDH), MRC validated the QA purpose for the potential unreported death process. Mortality Review Office (MRO)established this process to identify any missed deaths that may have occurred, allowing for investigation by OL and review by MRC.

MRC established a collaborative process with the OL Special Investigation Unit (SIU) related to mortality review to ensure a thorough clinical mortality review of documents within required timeframes.

In collaboration with Information Technology (IT) & Security Offices, the MRC developed a process to utilize §§2.2-3705.5, 2.2-3711, and the 2.2-4002 Amendment of the Code of Virginia authorizing the MRO to obtain medical records via an electronic, secure, limited access only, facsimile application(Sfax®).

During SFY21, 80.2% of cases reviewed by MRC were performed within 90 days of the individuals’ deaths.”

Under the Risk Management section, several areas of progress in QII were listed:

“A workgroup reviewed incident reports of urinary tract infections(UTIs)and made recommendations for additional support and education of providers to mitigate this risk. These recommendations included:

a. Reviewing and updating provider training and educational resources (atypical signs and symptoms of UTI, critical role of provider, provider 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, with a focus on developing more targeted and effective protocols which may either prevent, or extend time between reoccurrence)

b. Collecting and sharing sample policies, protocols, best practices related to preventing initial and recurrent UTIs

c. CMSC review of the role of the SC in assuring appropriate services in place for individuals with chronic/recurrent UTIs

d. Collaboration with MRC to better monitor and respond to trends

At the recommendation of RMRC, a specific checkbox was added to the CHRIS interface for providers to report individuals' receiving a positive diagnosis of COVID-19. This provided more accurate data on new COVID-19 cases and eliminated the need for manual review of the notes section of incident reports by DBHDS staff.

Office of Integrated Health (OIH) published monthly Health & Safety Alerts and newsletters on topics such as urinary tract infections (March 2021), sepsis (January 2021), choking (November 2020), and pressure injuries (July 2020). In addition, they published guidance for providers regarding vaccinating individuals with developmental disabilities for COVID-19 and posted a series of power point trainings on managing common health risks."

Under the Quality Improvement section of the plan, specific MRC QIIs were summarized:

"MRC continued the 911 QII, which addressed licensed DBHDS providers' staff failure to contact 911 first in emergencies. MRO collaborated with OIH and OL Special Investigative Team to increase awareness on the importance of calling 911. Training on the importance of calling 911 was provided as well as resource materials, distributed through alerts and newsletters. OPD revised the 911/Emergency protocol and updated the CM modules to indicate that 911 should be called first, rolling it out to providers through meetings (e.g., Roundtable and Quarterly). Although provider competencies indicated adherence to established provider policies, OPD updated the competencies to indicate that 911 should be called before notifying anyone else of an emergency and making other calls only after 911 was called. MRC case reviews found that providers increased their compliance to 911/Emergency protocol from 62% Q1 to 79% Q4 (target is 61%).

MRC developed a QII to address the number of death certificates available for MRC review. Having the death certificates available for review aided the committee in their review of cases and the determinations the committee made relative to cause of death, whether the death was expected/unexpected and, if unexpected, if the death was potentially preventable. MRC surpassed its target of 91% during each quarter of the year (Q1-98%, Q2-96%, Q3-96%, Q4-96%) with an overall rate of 97% of death certificates made available for review.

MRC developed two QIIs to address DBHDS provider knowledge of sepsis identification and ongoing assessment of the individual's change in status. The first sepsis QII focused on decreasing the number of deaths caused by sepsis, through the identification of the top two infectious factors not previously identified during MRC case reviews, and determining the training and education needed to address these factors. As aspiration pneumonia, pressure injury and UTIs are common contributing factors to sepsis, OIH provided training on these as part of a "Fatal 7" training. During the "Fatal 7" training, participants requested further training on sepsis to target areas such as symptom recognition, early awareness, individuals at risk, and resulting actions that should be taken. Data analysis resulting

from MRC case reviews and the training feedback supported a more comprehensive training on sepsis. 52% of cases reviewed identified a genetic disorder as the largest contributing factor to sepsis. Therefore, a new QII targeting a comprehensive sepsis training was identified. The second sepsis QII focused on providing a "stand-alone" sepsis training. OIH provided this training on June 4, 2021. OIH created a recorded training, which allowed providers to access it on demand on the COVLC site.

MRC proposed two QIIs during Q4 of the fiscal year that were approved on June 28, 2021:

- The first focuses on decreasing the COVID-19 mortality rate for the I/DD population as MRC had identified 50 COVID-19 related deaths as of May 17, 2021. Key components of this QII include continued education on vaccination, continued support for execution of infection control measures and enhanced surveillance and early detection of COVID-19.

- The second focuses on reducing the crude mortality rate of individuals with a Supports Intensity Scale (SIS) level 6, as the SFY20 crude mortality rate for SIS level 6 was 76.2 deaths/1,000 individuals. A key component of this QII focuses on addressing risk factors for heart disease, as data from SFY20 revealed that the top two causes of death for individuals with a classification of SIS level 6 were sepsis and sudden cardiac death."

Under the section; SFY21 DBHDS Internal Quality Management Program Evaluation,' the following was included concerning the MRC activities and challenges:

Used their work plan to note activities completed, in relation to the actions taken by MRC, in response to determinations made during case reviews; only those actions related to broader QI activities are noted as the majority of MRC actions are in response to the individual cases.

MRC's scope and purpose were reviewed, and determinations made as to whether the identified area was appropriate for MRC or another subcommittee to address.

MRC noted significant improvement in the availability of medical records for review; this was due to an amendment to the Virginia Code giving MRC the ability to request information. This improvement enhanced MRC's discussions and determinations.

MRC members assured that definitions used by the MRC, to guide them in their work, were used consistently by MRC, which supported their determinations of the cause of an individual's death, whether the death was expected, and if the death was potentially preventable) during case reviews.

MRC members participated actively in the determination of which QIIs to recommend to the QIC. MRC looks to expand their electronic mortality review form to capture additional data noted during case reviews, which will provide more accessible surveillance data to use in their recommendations for QIIs."

ATTACHMENT 20 CI #36.1

Documentation was submitted for verification of reliability and validity"

For the CI #33.9 "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 following attestation document was submitted:

'33.9 Attachment B Data Set Attestation 07.29.22' reviewed the data set (MRC Master Document Posting Schedule) reflecting the process and procedure of the Mortality Review Office and Mortality Review Committee. The Accountable Executive reviewed the process documents for completeness and representative of date intended for collection The Data Analyst Review described the process of the identified databases which were merged and cleaned, which verified there were no errors and data was valid.

For the CI #33.13 "86% of unexplained/ unexpected deaths reported through DBHDS incident reporting system have a completed MRC review within 90 days of death.", the following attestation document was submitted.

'33.13..33.15 Attachment B Data Set Attestation 07.29.22' reviewed the data set (MRC Master Document Posting Schedule) reflecting the process and procedure of the Mortality Review Office and Mortality Review Committee. The Accountable Executive reviewed the process documents for completeness and representative of date intended for collection. The Data Analyst Review described the process of the identified databases which were merged and cleaned, which verified there were no errors and data was valid.

Primary document review

Primary documents were reviewed for verification and reliability of content, and compared to the content described in the OL process and the MRC process, and subsequently summarized in the eMRFs. One individual's primary documents were reviewed per MRC meeting from August 12, 2021 through July 28, 2022. As there were 24 MRC meeting during this time period, primary source documents were reviewed for 24 Individuals selected from the Tier 1 category.

Primary source documents were reviewed for the following individuals: #279793, #133712, #1798099, #602254, #363720, #418290, #274846, #192929, #151010, #112937, #1358560, #1348260, #522160, #2653, #162837, #1841268. #1850339, #646191, #203812, #1043090, #261576, #1082040, #501515, #1807372.

Documents were categorized by subject content: Office of Licensing documents/CAPs, progress notes, medical records, annual physical exam, annual ISP, death certificate, incident reports, discharge summary, quarterly reports, and medication lists (from MARs, provider agency lists, hospital admission lists, etc.). These 10 categories were reviewed for each of the 24 individuals

selected. Some documents were not available primary source documents. In all, there was verification of reliability and validity in 203/210 documents. Compliance with this indicator (#36.1) was 96.7%.

APPENDIX F

Office of Licensing and Office of Human Rights

by

Ric Zaharia, Ph.D.

Consortium on Innovative Practices

TO: Donald Fletcher, Independent Reviewer

FROM: Ric Zaharia, Ph.D.

RE: Period 21 Report: Office of Licensing/Office of Human Rights (OL/OHR)

DATE: November 7, 2022

Introduction

For the 19th Period Review in 2021 we verified that both Offices reinstituted face-to-face, on-site activities, which were suspended during the pandemic, so they were able to resume demonstrating the achievement of applicable Compliance Indicators. We acknowledged OHR's accomplishment of cross-tabbing APS/CPS reports to ensure complete and accurate information for fuller accountability for timely incident reporting and to improve the accuracy of data with regards to timely reporting (Provision V.C.6). Documentation that was reviewed showed that OL followed up appropriately on CAPs for failure to report and had taken action when providers failed to effectively implement corrective actions. Timely reporting continued to meet the Compliance Indicator benchmark of 86% during FY21.

For the first time, DBHDS met the four Compliance Indicators (48.1-48.4) for the Adequacy of Supports framework (Provision V.G.3). In the 19th Period the OL process addressed seven of eight domains, while Crisis Service data points provided the source data for the eighth domain of Stability.

In addition, OL continued to utilize the provisional status designation as the primary negative consequence for provider agencies that did not successfully implement CAPs. The rate of use of this designation during FY21 is regarded as a sign of OL's commitment to improvements in oversight.

During the 19th Period Review DBHDS met seven of eight Compliance Indicators for timely incident reporting, Provision V.C.6 (34.1-34.8.) and four of four Compliance Indicators for Adequacy of Supports (AOS), Provision V.G.3 (48.1-48.4). Since DBHDS had not yet determined that the data sources for several of these Indicators were reliable and valid (specifically 34.4, 34.6, 34.8, and 48.4), Provisions V.C.6. and V.G.3. remained in non-compliance.

Summary of Findings 21st Period Review

The purpose of this study of OL/OHR was to determine whether the Commonwealth has sustained achievement for MET indicators for V.C.6 and V.G.3 and whether it has achieved the one NOT MET Indicator (34.5). Secondarily, the study will determine whether DBHDS has established the reliability and validity of its reported data sets through a review of Process Documents and Data Set Attestations, including actions to address and resolve previously identified threats to data integrity, completion dates, and appropriate application of the verification process. To ensure that the Commonwealth has maintained achievement, this review will also include Provisions V.C.2-3 and V.G.1-2, which have previously and consistently been found in Sustained Achievement. No Curative Actions were associated with this Indicator.

Methodology
As in the 19th Review, I reviewed documents and records (see Attachment A) to evaluate evidence and substantiate the extent to which the Commonwealth has achieved or sustained achievement of the Indicators. I also interviewed key staff (see Attachment B) in order to clarify areas and offer the Commonwealth additional opportunities to provide any information that would be helpful in reaching a conclusion about indicator achievements. Finally, I completed spot checks of the raw data and reports to verify the reliability and validity of data reported for indicators 34.1, 34.6 and 48.4.

V.C.6 – Timely Incident Reporting
DBHDS achieved all eight of the V.C.6 indicators. It sustained achievement on seven and it newly achieved one indicator, 34.5. Improvements were noted in the quality of CAPs being approved by OL and the precision of DBHDS tracking their implementation. However, DBHDS has only conditionally met indicators 34.4, 34.5, and 34.8

V.G.3 – Adequacy of Supports (AOS)
DBHDS sustained achievement on four of four Indicators (48.1-4). OL has embraced the AOS framework through its organization of the regulatory data (case management versus provider services), introducing a data element for Stability in the case management domain, and its expanded use of the framework in other non-IDD service areas of DBHDS (Substance Abuse, Behavioral Health).

Prior to the March 2020 introduction of the Adequacy of Supports framework, the one hundred plus OL regulations relevant to IDD were not prioritized. This Compliance Indicator for the AOS "checklist" (48.1) required that it be tied to OL's "corresponding regulations". The AOS now includes 27 regulations organized across provider rules and case management service rules and across eight domains. External Crisis Service data points provide the source data for the eighth domain of Stability for provider services and face-to-face case management contacts provide the source data for the domain of Stability for case management services. This dimension of the Stability domain could not be fully assessed until pandemic restrictions were lifted last year. This latter application of the framework to AOS (case management/stability) prompted OL to raise data-based concerns about case manager performance with the CMSC in the Spring of CY22.

Although identified as a "checklist", Adequacy of Supports has become much more in the Office of Licensing schema. Previously Licensing Specialist (and Providers) focused equally on all regulations. Now, with the AOS framework Licensing Specialists and Providers were guided to emphasize 27

key and 44 reference regulations that reflect the theme of the seven AOS domains. All regulations are available for citation, but these AOS-specific regulations must be assessed.

The AOS framework assures that the minimum regulatory thresholds of service delivery are assessed for the eight domains. The sample of individuals drawn at inspections are assessed by the Licensing Specialist (LS) via the ISP, formal evaluations, and individual risk assessments. The individual and the daily record are then reviewed to confirm that the needed services are being delivered per the ISP. If a regulation is not met, the LS makes a determination that the adequacy of the individual's supports is not sufficient, the provider is cited for that individual and a corrective action plan is required. This same approach is used regardless of the individual's medical or behavioral level of need. Later OL protocols have clarified and specifically outlined for Licensing Specialists as to what to look for to determine adequacy of supports.

The accuracy of the data collected under the AOS framework is enhanced via an OL look-behind process using its Regional Managers to review all inspection/investigation reports; in addition, OL has recently had the Regional Managers conduct concurrent but separate inspections to establish inter-rater agreement levels with Licensing Specialists. These Regional Managers communicate with OL leadership regularly and meet formally quarterly, which serves as a quality feedback loop to inform OL leadership of interpretation problems, needed regulation clarification, and other application issues.

V.G.1-2 and V.C.2-3 – Previously Achieved Provisions
DBHDS has sustained compliance with these previously achieved provisions and has made numerous changes to incident reporting systems which improve user interface, provider access and overall data integrity**.** Regular unannounced inspections continue and are utilized to follow up citation CAPs on incidents that are not serious.

Process Document & Attestation
For Indicator 34.3 DBHDS submitted the Process Control document for the Medicaid Claims Match study and its Data Set Attestation form. These were reviewed and are appropriately responsive to issues surrounding the study. The process steps are detailed and clearly stated. The numerator and denominator are correctly stated for the metric in Indicator 34.4 (86%). No issues were reported from IR Reports or the DQV. The DBHDS Chief Information Officer reviewed and affirmed the integrity of the information by attesting to the reliability and validity of the data that was collected for this Indicator. No threats to data integrity have been previously identified except those related to timely incident reporting in CHRIS (see 34.4), therefore no data verification was conducted.

For Indicator 34.4 DBHDS submitted the Process Control document for the timely incident reporting data and a Data Set Attestation form (combined with Medicaid Claims Match Data Set Attestation). The former was reviewed and is appropriately responsive to issues surrounding the study. The process steps are detailed and clearly stated. The numerator and denominator are correctly stated for the metric in Indicator 34.4 (86%). The DQV has recommended the replacement of the entire incident reporting system, however, the Office of Licensing implemented interim steps to address data integrity problems, e.g., the Incident Management Unit (IMU) has been tasked with and completed manual tracking and filtering of duplicate, unnecessary, or system outage reports. In addition, there are unaddressed issues in DBHDS's 8.19.22 Key Performance Area (KPA) Performance Measure Indicator (PMI) document. The DBHDS Chief Information Officer reviewed

the integrity of the information and attested to the reliability and validity of the data that was collected for this Indicator, however, this was completed in tandem with the Medicaid Claims Match study which has a parallel but different purpose. Therefore, this indicator is conditionally MET pending the development of an updated Process Document and a Data Set Attestation document unique to systemwide timeliness reports. Threats to data integrity previously identified include: 1) time element on data of discovery; source fields were updated to include time of discovery and is reflected in FY22 timeliness data. 2) CHRIS data reports vary from concurrent Data Warehouse reports incidents not reported during an outage; CHRIS replacement is proposed solution but the IMU is completing manual sorting, tracking and prioritizing reports; this interim resolution is ongoing, 3) reliable notification of system outages - this a timeliness issue and does not impact summary reporting over months-quarters-years, 4) unique identifiers; the IMU is tasked with manual sorting, tracking and prioritizing reports, which includes clearing duplicates and 5) incorrect service mapping reported within source systems; no immediate resolutions reported, but this is not considered by this reviewer as critical to this Indicator.

For Indicator 34.6 DBHDS submitted the Process Control document for the CAP implementation data and its Data Set Attestation form. The former was reviewed and is appropriately responsive to issues surrounding the study. The process steps are detailed and clearly stated. The numerator and denominator are correctly stated for the metric (86%). Although this Indicator is triggered by CHRIS reports, no threats to data integrity have been identified in the manual tracking of CAPs via data warehouse by OHR. Nonetheless, the DQV has recommended the replacement of the entire incident reporting system, and a written manual work-around process has been implemented to address data integrity problems; e.g., the IMU completes the manual tracking and filtering of duplicate, unnecessary, or system outage reports. The DBHDS Chief Information Officer attested to the reliability and validity of the data that was collected for this Indicator. Before this process, the CHRIS reports were determined to be submitted on-time at a 93% rate. Once the manual data manual filtering process was completed, the CHRIS reports were found to be submitted timely at a 97% rate. Threats to data integrity previously identified include: 1) time element on date of discovery; source fields were updated to include time of discovery and is reflected in FY22 timeliness data. 2) CHRIS data reports vary from concurrent Data Warehouse reports incidents not reported during an outage; CHRIS replacement is proposed solution but the IMU is tasked with manual sorting, tracking and prioritizing reports; this interim resolution is ongoing, 3) reliable notification of system outages - this a timeliness issue and does not impact summary reporting over months-quarters-years, 4) unique identifiers; the IMU is tasked with manual sorting, tracking and prioritizing reports, which includes clearing duplicates, 5) incorrect service mapping reported within source systems; no immediate resolutions reported, but this is not considered by this reviewer as critical to this Indicator, and 6) inability to match Data Warehouse reports at different points in time; incident reporting is ongoing, so the number of reports for January, if looked at in February, will be different from the number of reports looked at in March because late reports are continuously added to the system.

For Indicator 34.8, DBHDS submitted the Process Control document for Training Center Incidents but no Data Set Attestation form. Since OHR process is triggered by a CHRIS report, the Process Control document is appropriate. However, this is qualified by the existence of a parallel process at the facility in the form of an on-site Facility Advocate who reports directly to OHR, Policy (#28) requires that *"When a violation of the Human Rights Regulations is identified in a state operated facility, the Facility Advocate Manager or assigned Facility Advocate shall notify the Facility Director by utilizing the Notice of Human Rights Violation letter."* This parallel process works independently to ensure the reliable

reporting of serious incidents, deaths, and allegations of abuse. When a CHRIS Data Set Attestation is provided, it would apply to this Indicator. However, given the parallel reporting mechanism in place, data verification of the human rights tracking process is not necessary. For Indicator 48.4 DBHDS submitted the Process Control document for the Adequacy of Supports data and its Data Set Attestation form. The former was reviewed and is appropriately responsive to issues surrounding the study. The process steps are detailed and clearly stated. The Compliance Indicator does not require a metric benchmark, but OL has established metrics for internal use and these are appropriately identified. AOS data now relies on the data from CONNECT, so the Process Control document identifies no issues as threats to the reliability and validity of data that were not corrected through the transition from OLIS This transition is not referenced in the Process Control document, but OL and ODQV documents separately identify the modifications and updates implemented to establish the CONNECT system, and the problems (threats) they were intended to address (see #34-35). Specifically,

> *In transitioning from OLIS to CONNECT, the Office of Licensing ensured that data validation constraints were placed on the system, including the addition of dropdown menus, check boxes, restricted fields, and system logic that will prevent cases from being closed prematurely. Further, CONNECT also has fields that auto-populate based on selections made in other fields…. Lastly, CONNECT interfaces with CHRIS-SIR for the investigation of serious incidents, late reporting citations, and for routine background checks of providers applying for licensure of services. (#34)*

The DBHDS Chief Information Officer reviewed and affirmed the integrity of the information by attesting to the reliability and validity of the data that was collected for this Indicator. Because this data system has changed, it will need to undergo review by ODQV for the 2023 update to the DBHDS Data Quality Monitoring Plan.

Table 1 - Data Integrity Documents

	Process Control Documents	**Data Set Attestation**
34.2-3	DOJ Process – Medicaid Claim Match (#33)	Data Set Attestation Form- DMAS Claims Match & CHRIS data, 9.26.22 (#49)
34.4	DOJ Process – Licensing Asmt Incident Report (#39)	Data Set Attestation Form- DMAS Claims Match & CHRIS data, 9.26.22 (#49)
34.6	DOJ Process – Corrective Action Implementation (#41)	Data Set Attestation Form – Corrective Action Implementation, 9.28.22 (#50)
34.8	DOJ Process – Training Center Incidents… (#40)	
48.4	DOJ Process – [Adequacy of Supports], 6.28.22 (#58	Data Set Attestation Form-Adequacy of Supports, 9.19.22 (#48)

Compliance Indicator Achievement

Table 2 below recaps this consultant's verification of the Commonwealth's achievement and sustained achievement with these Indicators. In summary, DBHDS achieved eight of eight Indicators for timely incident reporting, Provision V.C.6 (34.1-34.8.) and four of four Indicators for Adequacy of Supports, Provision V.G.3 (48.1-48.4). Since DBHDS has installed a new reporting system that addresses known threats and this consultant reviewed look behind concurrent review

data for a sample of 5 agencies, this consultant verified that the data reported for Provision V.G.3 are reliable and valid; the data sources for Provision V.C.6 have not been determined to be reliable and valid. Finally, DBHDS sustained its achievement of Provisions V.G.1-2 and V.C.2-3.

Table 2
Compliance Indicator Table

VA#	V.C.6 – OL/OHR - Failure to report Compliance Indicators	Facts	Analysis/Conclusions	19th Report	21st Report
34.1	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/OHR continue to identify and track late incident reporting by provider agencies, including CSBs, through inspections and investigations (see #12-13, 42-43) Procedures are in place to investigate OL/OHR identified issues, as well as complaints from external agencies or from providers, family members, or others (see #20-22, 25-26). Deaths are reported quarterly by VDH and tracked by OL to ensure provider reporting (see #46).	Sustained achievement	MET	MET

VA#	V.C.6 – OL/OHR - Failure to report Compliance Indicators	Facts	Analysis/Conclusions	19th Report	21st Report
34.2	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	DBHDS again conducted a quarters cross-tab analysis of Medicaid claims for emergency rooms and hospitalizations with CHRIS incident reports for Q1 FY22 (see #32); OIH outreach to providers, who made the Medicaid claim, then classified explanations as 'not excused' or 'excused' (e.g., individual was with family); these analyses showed that for this quarterly period 2,302 of 2,681 serious incident reports were considered timely (86%). See #45.	Sustained achievement	MET	MET
34.3	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	DBHDS again conducted one quarters cross-tab analysis of Medicaid claims with CHRIS incident reports for the third year in a row, Q1 FY22, including across the three waivers and three residential services (see #32, 59). DBHDS completed the Process Control Document (#33) and Data Set Attestation (#49) for the Medicaid claims match study. No threats to data integrity have been previously identified except those related to timely incident reporting in CHRIS (see 34.4), therefore no data verification was conducted.	OL has made regulatory changes which should clarify that all emergency hospitalizations require incident reports; this should positively impact future Medicaid claims studies. Sustained achievement.	MET	MET

VA#	V.C.6 – OL/OHR - Failure to report Compliance Indicators	Facts	Analysis/Conclusions	19th Report	21st Report
34.4	4. At least 86% of reportable serious incidents are reported within the timelines set out by DBHDS policy.	DBHDS reports a 97% timeliness rate in FY22 after filters are applied (see #12, 31-32); the unfiltered rate of 9787/10569 incidents (93%) still show achievement with this metric. This includes APS/CPS reports, OL reviews during annual inspections, and deaths reported by VDN. DBHDS completed the Process Control Document (#39) for the timeliness report and a Data Set Attestation Form was provided (see #49. However, the most recent KPA PMI (#62) identifies several unresolved data integrity issues, which are not listed in the Process Document. While the Medicaid Claims Match study and the systemwide timeliness study have parallel purposes, they are not interchangeable. Therefore, a unique Data Set Attestation is needed for timeliness.	Achievement was sustained; however, data integrity was not established through a satisfactory Process Document and Data Set Attestation.	MET*	MET*
34.5	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-	OL & OHR continue to track agencies cited for late incident reporting (see #16). OL requested CAPs and retraining of agencies that filed untimely late reports three or more times 7/21 to 8/22 (see #14-15). OL continues to track agencies cited for late reporting CAPs and annual inspection follow-up (see #17). CAPs and follow-up were reviewed from Q3 FY21 (see #37). CAPs reviewed for this study reflected a trend of initial rejection and rewrite of inadequate CAPs, requiring process descriptions to ensure timely reporting, end of shift check off reports, QA retrospective audits, weekly manager reviews, etc.	OL/OHR have systematically improved their tracking of late reporting over the last two review cycles. Agency corrective action plans reviewed for this study also indicate an elevated level of attention to tracking the timely reporting of incidents. DBHDS has achieved this achievement indicator. Because of its association with the CHRIS data set, the rating for 34.5 is conditional for the	NOT MET	MET*

VA#	V.C.6 – OL/OHR - Failure to report Compliance Indicators	Facts	Analysis/Conclusions	19th Report	21st Report
	approved corrective action plans.	If failure to correct is also noted in an annual inspection, agencies are cited for failure to implement the CAP (12VAC35-105-170) and continued failures result in systemic citations (see #38).	same reasons as 34.4 above		
34.6	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	This study confirmed that OL has identified the format for CAP submissions (see #23), tracks annual inspections and investigations (see #24, 42-43) a.& b. OL has issued revised instructions on the handling of serious injury and death CAPs, including 45-day follow up on implementation (see #19). b. OL has issued revised instructions on the handling of CAPs for incidents that do not involve serious injury or death, including 90-day follow up (see #19). c. OL tracks additional negative actions for providers who fail to correct issues after CAPs (see #18). During the period 6/21 to 7/22 OL pursued negative actions against 18 providers resulting in consent agreements, voluntary closure, or provisional licensing (see #18). Since the last review period, DMAS has determined that it will not pay claims past 60 days to providers with provisional licenses, which has raised the stakes for providers who fail to implement CAPs. For the period 10/21 to 3/22 OHR determined that 94% of CAPs (323/342) were closed due to implementation within 90 days (see #42-43).	DBHDS has fulfilled this indicator for two review cycles. Sustained achievement	MET*	MET

VA#	V.C.6 – OL/OHR - Failure to report Compliance Indicators	Facts	Analysis/Conclusions	19th Report	21st Report
	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 appropriate action as determined by the Commissioner in accordance with the Licensing Regulations.	OHR provided a Process Control Document (#41) and Data Set Attestation Form (#50). Although this Indicator is triggered by CHRIS reporting, no threats to data integrity have been identified in the manual tracking of CAPs via data warehouse by OHR. Because DQV has recommended the replacement of the entire incident reporting system, OHR has implemented a written work -around process to address data integrity problems., e.g., the IMU completed the manual tracking and filtering of duplicate, unnecessary, or system outage reports. CAPs and follow-up were reviewed from Q3 FY21 (see #37).			
34.7	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.	OL tracks additional negative actions for providers, including CSBs, who fail to correct issues after CAPs (see #18). This review verified that during the period 6/21 to 7/22 OL pursued negative actions against 18 providers resulting in consent agreements, voluntary closure, or provisional licensing (see #18).	Sustained achievement	MET	MET
34.8	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	OHR has policies in place that specify requirements for Training Centers to report serious incidents and implement corrective actions (see#27-28). a. OHR has a process to track the implementation of corrective actions at Training Centers (see #29)	Sustained achievement.	MET*	MET*

VA#	V.C.6 – OL/OHR - Failure to report Compliance Indicators	Facts	Analysis/Conclusions	19th Report	21st Report
	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.	b. OHR reviews incidents monthly and annually to determine if identified causes have been addressed (see #29-30). OHR provided a Process Control Document (#40). Since the OHR is triggered by a CHRIS report, the Process Control document is appropriate, although no Data Set Attestation form has been provided for CHRIS. However, this is qualified by the existence of a parallel process at the facility in the form of an on-site Facility Advocate who reports directly to OHR, Policy (#28) requires that *"When a violation of the Human Rights Regulations is identified in a state operated facility, the Facility Advocate Manager or assigned Facility Advocate shall notify the Facility Director by utilizing the Notice of Human Rights Violation letter."* This parallel process works independently to ensure the reporting of serious incidents, deaths, and allegations of abuse.			

VA#	V.C.2 and V.C.3.	Facts	Analysis/Conclusions	19th Report	21st Report
NA	The Commonwealth shall have and implement a real time, web-based incident reporting system and reporting protocol.	DBHDS has updated or revised CHRIS and OLLIS (now CONNECT) to better ensure the integrity of data entry (see #35). These changes have improved user interfaces and have narrowed options via the use of dropdown boxes.	Sustained achievement	MET	MET
NA	The Commonwealth shall have and implement a process to investigate reports of suspected or alleged abuse,	DBHDS continues to operate a process to investigate reports of suspected or alleged abuse, neglect, critical incidents, or deaths and identify remediation steps taken. (See #6, 20, 21, 25, 26, 28, 36)	Sustained achievement	MET	MET

	neglect, critical incidents, or deaths and identify remediation steps taken.				

VA#	V.G.1 and V.G.2	Facts	Analysis/Conclusions	19th Report	21st Report
NA	*Settlement Agreement* *V.G.1 "The Commonwealth shall conduct regular, unannounced licensing inspections of community providers serving individuals receiving services under this Agreement.*	This study verified that DBHDS continues to rely on regular, at least annual, unannounced inspections to ensure quality services (see #36).	Sustained achievement	MET	MET
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 continues to address these requirements in its inspection protocol (see #36). OL's Incident Management Unit monitors care concerns and incident reporting for interruptions in services and for encounters with the crisis system; when appropriate, cases are flagged for licensing specialists to ensure increased monitoring and inspection. (See #6, 20, 60, 61)	Sustained achievement	MET	MET

VA #	V.G.3 – OL - Adequacy of Supports Compliance Indicators	Facts	Analysis/Conclusions	19th Report	21st Report
48.1	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 data from other sources that	OL has utilized the AOS checklist for two full calendar years and has continued to provide data for 7 of the 8 domains listed in V.D.3. It has used data from other sources to inform achievements in the 8th domain (Stability) for	Sustained achievement	MET	MET

VA #	V.G.3 – OL - Adequacy of Supports Compliance Indicators	Facts	Analysis/Conclusions	19th Report	21st Report
	assess the adequacy of individual supports and services in those domains not covered by the OL checklist.	provider services. OL has also added case manager face-to-face visit citation data to inform achievements in the Stability domain for case management services. (See #1-5, 52-54). This commitment to the AOS framework prompted OL to discuss data-based concerns about case manager performance in this domain to the attention of the CMSC in the Spring of CY22 (see #51).			
48.2	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	OL utilizes the AOS checklist during all annual inspections and investigations (see #6-7). For OL inspections and investigations, LSs are trained with guidance that poses questions or the necessary evidence to show regulatory achievement with the framework (see #57). Reliability is established with regional manager look-behinds of licensing specialist's inspections. This review verified that OL recently conducted five (5) inspections where reliability was checked by secondary on-site inspections by regional managers, which showed very high percentages of inter-rater agreement (#55).	Sustained achievement	MET	MET
48.3	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	OL distributed information to providers on how it assesses AOS (see #8) and provided updates to providers (#11) on the	Sustained achievement	MET	MET

VA #	V.G.3 – OL - Adequacy of Supports Compliance Indicators	Facts	Analysis/Conclusions	19th Report	21st Report
	providers of its expectations regarding individualized supports and services, as well as the sources of data that it utilizes to capture this information. e	AOS/Inspection process (see #9). An annual webinar update is scheduled for 10/22 (see #7).			
48.4	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 continues to track AOS regulations, issues summary reports, and shares semi-annually the data with the CMSC and KPA work groups (see #1-5, 52-54). Improvement initiatives have generated from this data and its distribution, e.g., new training materials, targeted trainings, quality management website with resource links, and the hiring of an OL training coordinator and an OL assistant director for quality (see #3, 52). -OL reports show that 88% of over 27,800 AOS provider regulations reviewed in CY21 were in compliance; the *Safety &Freedom from Harm and Provider Capacity* domains fell below 86% (see#47). -OL reports show 89% of over 1,100 AOS case management regulations reviewed in CY21 were in compliance; the *Stability, Provider Capacity*, and *Community Inclusion* domains fell below 86% (see #47). These trends reported by OL continued into CY22 (see #52): -OL reports show that 87% of 16,774 AOS provider regulations	Achievement was sustained.	MET*	MET

VA #	V.G.3 – OL - Adequacy of Supports Compliance Indicators	Facts	Analysis/Conclusions	19th Report	21st Report
		reviewed 1/22-6/22 were in compliance; the *Safety &Freedom from Harm and Provider Capacity* domains again fell below 86%. -OL reports show 89% of 1,093 AOS <u>case management</u> regulations reviewed/22-6/22 were in compliance; the *Stability, Provider Capacity*, and *Community Inclusion* domains again fell below 86%. A Process Control document (#58) and a Data Set Attestation form (#48) were submitted for AOS. AOS data now relies on the data from CONNECT, so the Process Control document identifies no issues as threats to the reliability and validity of data that were not corrected through the transition from OLIS. This transition is not referenced in the Process Control document, but OL and ODQV documents separately identify the modifications and updates implemented to establish the CONNECT system, and the problems (threats) they were intended to address (see #34-35). This study included a look-behind review that verified the reliability of the data reported for 48.4. Because this data system has changed, it will need to undergo review by ODQV for the 2023 update to the DBHDS			

VA #	V.G.3 – OL - Adequacy of Supports Compliance Indicators	Facts	Analysis/Conclusions	19th Report	21st Report
		Data Quality Monitoring Plan.			

*Conditionally met until data is determined to be reliable and valid.

Recommendations:

1. OHR should consider requesting that facility directors submit their root cause analysis along with their corrective actions to ensure the presenting problem is addressed.

2. The recent curtailment of reimbursement payments to providers on provisional status after 60 days is a positive development for OL enforcement activities, but OL should consider discussions with DMAS about the use of a longer 'hold harmless' period for providers; few providers can implement new procedures and show outcomes for corrective actions within 60 days.

3. Because investigations applying the AOS framework will very likely skew negative, OL should consider analyzing annual inspection data separately from investigation data.

Attachment A

Documents Reviewed

1. 2nd Semi-annual report (7.1.20 to 12.31.20-AOS)
2. 3rd Semi-annual report (1.1.21 to 6.30.21-AOS)
3. Annual Trend Report (1.1.21 to 12.31.21-AOS)
4. 2nd Annual Trend Report to CMSC (AOS PowerPoint), undated.
5. 4th Semi-Annual Report to QIC (6.27.22 AOS PowerPoint), undated
6. OL Protocol for Assessing Serious Incident Reporting by Providers of Developmental Services (IMU), revised 2/22
7. Email, Benz to Zaharia, 8.30.22
8. Correspondence to Providers, 3.14.20
9. Statewide Provider Roundtable Webinar, 10.26.21
10. 2022 OL Annual Checklist Achievement Determination Chart, 3.11.22
11. 2022 Annual Inspections for Providers of Developmental Services, 2.10.22
12. DSi late reporting- 1.1.21 to 3.31.21
13. External complaints regarding Incidents and Deaths (160D.2: 1/22 to 8/22)
14. Letters for 3 or more citations… (48 letters during the period 7.15.21 to 8.17.22)
15. Training attestations for 3 or more citations… (61 during a rolling year)
16. One or more citations for late reporting, 1.1.22 to 6.30.22 (tracking report)
17. Late Reports_KRC160D2 (Q3FY21 providers cited for late reports/CAPs/Annual follow-up)
18. Tracking form for enforcement and negative actions (6/21 to 7/22)
19. Health & Safety CAP Process, revised (undated)
20. Protocol No 317-OHR Role in OL IMU…,7/20
21. Protocol No. 309 – AIM, 6.1.22
22. Facility OSIG Complaint Process, 8.6.21
23. Combined CAP Templates for Serious Incident Reporting, undated.
24. Licensing Regulation Achievement – Annual and Investigations, 8.31.22
25. Protocol No 313 – OHR Triage Process, 10.13.21
26. Protocol No 316 – OHR Role in the CAP Process…, 4.1.22
27. Facility Violation Letter, Goldman to Facility Directors, 1.7.21
28. Protocol 315 - OHR Violation Notice for State Operated Facilities, 10.13.21
29. Summaries of Violation letters for State Facilities, 12/21, 1/22, 2/22, 3/22, 4-6/22
30. Violation Letters FY22 Annual Report…, undated.
31. Summary Data Collection (34.4), undated.
32. Follow up on Medicaid Claims Review (Summary Report on Medical Claims Review/Timely Reporting of Serious Incidents) 2022.
33. DOJ Process – Medicaid Claim Match, 6.16.22
34. DQMP Annual Update June 2022
35. Updates to System CHRIS_ SIR_CONNECT, undated
36. Office of Licensing DD Inspection Protocol, undated.
37. Annual Inspections/CAP follow-up (43 from Q3FY21)
38. Email exchange, Benz to Zaharia, 9.23.22
39. DOJ Process – LIC Asmt Incident Report…, undated

40. DOJ Process – Training Center Incidents…., undated
41. DOJ Process – Corrective Action Implementation, undated
42. DW 0071- OHR 90 days Q2FY22
43. DW 0071 OHR 90 days Q3FY22
44. Implementation of the DBHDS licensure process assesses the adequacy of the individualized supports…., undated.
45. Email Nair to Zaharia, 9.26.22
46. VDH MRC Data Report Q42022
47. Adequacy of Supports (CY2021)
48. Data Set Attestation Form – Adequacy of Supports, 9.19.22
49. Data Set Attestation Form – DMAS Claims Match & CHRIS data, 9.26.22
50. Data Set Attestation Form – Corrective Action Implementation, 9.28.22
51. CMSC Report FY22 3rd and 4th Qtr., 10.14.22
52. Adequacy of Supports 5th Semi-Annual…. (1.1.22-6.30.22)
53. Adequacy of Supports 1.1.22 to 6.30.22 (data analysis)
54. Data Request…1.1.22 to 6.30.22 (provider stability measure)
55. Consolidated RM Look Behinds for AOS, undated (5 inspections during CY22)
56. Office of Licensing Look Behind Process…, 2/22
57. OL annual checklist achievement determination chart, 4.29.21.
58. DOJ Process [Adequacy of Supports – incorrectly labeled/see footer], 6.28.22
59. Internal Process Document Medicaid Claims, 2022
60. Licensing DD Inspection Protocol, undated
61. IMU Care Concern Threshold Joint Protocol, 9.2.21
62. KPA PMI, 8.19.22

Attachment B

OL/OHR Interviews

Name	Title	Date
Jae Benz	Director, Office of Licensing, DBHDS	9.23.22, 10.20.20
Dev Nair	Asst. Commissioner, Division of Provider Management	9.23.22 & 9.30.22 10.20.20
Taneika Goldman	Director, Office of Human Rights, DBHDS	9.30.20
MacKenzie Glassco	Assistant Director, Quality & Achievement OL	10.20.20

APPENDIX G

Provider Training

by

Chris Adams, MS

Provider Training and Competency Assessment 21st 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). 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 21st 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.

Section V.H of the Agreement requires that the Commonwealth have a statewide core competency-based training curriculum for all staff who provide services under this Agreement. Compliance with these provisions has been reviewed in the 5th, 7th, 10th/11th, 15th, 17th, and 19th 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.

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 in 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 at the Department of Medical Assistance Services (DMAS and DBHDS were approved and became effective on 03/31/2021. These revised regulations expanded requirements for waiver- funded providers to ensure the provision of core competency-based training for persons responsible for direct delivery of services and supports for waiver participants.

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. The details included sixteen Compliance Indicators for V.H.1 and V.H.2 that emphasize the importance of specific core competencies across the system. 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.

Initially, DMAS was responsible for the primary regulatory oversight of provider implementation of core competency-based training through their Quality Monitoring Review (QMR) process. However, DMAS's

QMR process does not have a sample size sufficient to generalize results to the entire provider community, does not include review of the provider's employee training policies, and does not include in-person assessment of DSP and DSP Supervisor competencies prescribed in this Compliance Indicator. Recognizing the concern about the small number of waiver providers reviewed through the QMR process during each 12-month period and the absence of in person assessment of DSP competency in delivering services, the Commonwealth developed a Curative Action (Curative Action #10) approved by the parties through the Joint Filing of Agreement on Curative Action dated 10/29/2021. This Curative Action added specific in-person monitoring requirements and protocols to the Quality Services Review (QSR) process completed by the Health Services Advisory Group (HSAG). The stated outcome for this Curative Action is to "ensure that DSPs and DSP supervisors meet training and core competency requirements, including demonstration of competencies."

The Independent Reviewer's 19th Report to the Court, dated 12/13/2021, concluded that the Commonwealth 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 met nine Indicators 49.01, 49.05–49.11 and 49.13, but did not fulfill the requirements of four Compliance Indicators 49.02, 49.03, 49.04 or 49.12. Therefore, the Commonwealth remained in Non-Compliance with this Provision. Regarding Provision V.H.2., Virginia once again met this Provision's three Compliance Indicators 50.01– 50.03, and, therefore, has achieved Sustained Compliance.

For this 21st Period study, 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 that included sampling compliance with provider training requirements.

Study Purpose and Methodology:
Primary focus of this study is on those Compliance Indicators that the Commonwealth has not previously provided sufficient evidence that the requirements of the Compliance Indicator were met. Those Compliance Indicators include 49.2, 49.3, 49.4, and 49.12.

Secondary focus is on the Compliance Indicators where evidence was sufficient to demonstrate that the Commonwealth met the requirements in the Indicator for the first time during the 19th period study. Those Compliance Indicators include 49.10 and 49.11.

This study also confirms that the Commonwealth has maintained sustained compliance for ten Compliance Indicators, which the Independent Reviewer determined that Virginia met in both his 17th and 19th Reports to the Court. Those Compliance Indicators include 49.1. 49.5. 49.6, 49.7, 49.8, 49.9, 49.13, 50.1, 50.2, and 50.3.

The methodology for this study includes gathering and investigating facts and verifying data and documentation provided by the Commonwealth to assess the sufficiency of the Commonwealth's actions to achieve and sustain achievement of each of the Compliance Indicators associated with Provisions V.H.1 and V.H.2. Evidence gathering activities included:

- Review of documentary evidence provided by the Commonwealth specific to the requirements set out in each Indicator.
- Review of any changes that have been made to policies, procedures, and/or practices relating to the requirements in the Compliance Indicators for which the Commonwealth has maintained sustained compliance identified through previous studies.
- Interviews with staff from DBHDS, DMAS, and the Health Services Advisory Group (HSAG), the Quality Services Review vendor, who have a working knowledge of the processes and procedures

employed by the Commonwealth through DMAS QMR, DBHDS Licensing inspections, and QSRs conducted by HSAG. The purpose of these interviews is to evaluate the sufficiency and accuracy by which the processes assess how providers ensure that DSPs and DSP Supervisors meet training and core competency requirements, including competency demonstration.

- Review of data and information gathering processes, data analysis, and findings from the most recent QSRs that assessed whether DSPs and DSP Supervisors met training and core competency requirements, including competency demonstration. This new/expanded process, implemented during the most recent round of QSRs, is described in Curative Action #10.

This study included a qualitative review of the DMAS QMR, DBHDS Licensing Inspection, and HSAG QSR processes and findings relevant to the assessment of whether DSP and DSP Supervisor training and core competency requirements, including competency demonstration, is occurring as required by relevant DMAS and DBHDS regulations. The qualitative review sample included ten providers (private providers and Community Services Boards) that had completed a licensing inspection and a 3rd round QSR during the past year. 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:

- Two providers in Region 1, two providers in Region 2, two providers in Region 3, one provider in Region 4, and three providers in Region 5.
- Three Community Services Boards (CSBs) and seven private providers.
- Types of services provided and number providing that type of service included Group Day Support (4 providers), Residential Supports (7 providers), Sponsored Residential Services (2 providers), Supportive Services (5 providers), and Case Management (3 providers).

Onsite interviews were conducted with the sample providers focusing on their policies, processes, and procedures to implement required DSP and DSP Supervisor training, core competency and competency demonstration; challenges they identified in complying with existing regulations relevant to DSP and DSP Supervisor training and core competency/competency demonstration; and obtaining feedback relevant to the QSR, QMR, and Licensing inspection assessments of their compliance with the training and core competency requirements.

The study activities included review of documents provided by DMAS and DBHDS, interviews with 3 DMAS staff, 3 DBHDS staff, 2 HSAG staff, a review of reports from 9 DMAS QMRs of sample providers, a review of 20 reports from annual licensing inspections for the 10 sample providers, QSR reviews for 10 sampled providers, review of training policies from the 10 sample providers, and 10 onsite interviews with provider staff in Norfolk (2 private providers), Virginia Beach (1 private provider), Waverly (1 private provider), Richmond (1 private provider), Annandale (1 private provider), Point Royal (1 CSB), Staunton (1 CSB), Abingdon (1 CSB), and Galax (1 private provider). A complete list of individuals interviewed for the study is included in Attachment A to this report. A complete list of documents and information reviewed may be found in Attachment B.

The study also included a data validation process for data that is used to measure achievement of requirements with Compliance Indicators 49.4 and 49.12 based on information provided by the Commonwealth, if made available, in the form of process documents and data validity and reliability attestation statements that focus on threats to data integrity previously identified by DMAS/DBHDS assessments; actions taken by DMAS/DBHDS that resolved these problems including completion dates for those activities; review of the verification process that DMAS/DBHDS completed that confirmed that the data reported is reliable and valid; and the date when the Commonwealth's Attestation that the Process Document was properly completed, noting that the data reported are reliable and valid.

Summary of Findings:

The Commonwealth has continued to progress in its implementation of a statewide core competency-based training curriculum and to structure and conduct thorough and reliable regulatory oversight of provider implementation of this program designed to ensure that DSPs and DSP Supervisors are competent to implement the elements of each Individual Support Plan for which they are responsible. 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. As restrictions related to the COVID-19 pandemic have relaxed somewhat, many providers continue to experience significant staffing shortages and high turnover rates in their direct support workforce and in their clinical staff and contract support. These workforce challenges are not unique to Virginia, but they increase the necessity of staff training, competency development, and the challenge to ensure procedural integrity in staff training programs heavily burdened with a revolving door of staff members who often do not remain in direct support positions for a sufficient time to gain competency and achieve proficiency in the skills and abilities necessary to meet the challenges of successful implementation of individual support plans.

After a lengthy period of restricted onsite inspections and visits, the DBHDS Office of Licensing, the DMAS QMR staff, and HSAG have resumed onsite inspections and quality reviews which has increased the effectiveness of these regulatory and quality oversight processes.

With revised waiver regulations in place for more than one year, DBHDS and DMAS have focused primary attention on process refinement rather than initiation of new program requirements. Given the workforce challenges facing the provider community, this approach appears warranted and it has afforded opportunities to evaluate processes and procedures and make necessary refinements to more effectively improve the agency's ability to achieve desired outcomes.

The most significant change that has occurred related to the implementation and oversight of the statewide core competency-based training curriculum and related requirements in Section V.H of the Agreement has been the implementation of process changes outlined in Curative Action #10 submitted to the Court in a joint filing of agreement in 10/29/2021. The process changes outlined in this Curative Action transfer responsibility for assessment of providers' implementation of the core competency-based training program from the DMAS QMR process to a more specifically designed assessment incorporated into the QSR process conducted by HSAG. In this revised process, HSAG reviewers conduct onsite interviews, observations, and record reviews to answer a set of specific questions to assess the success of the provider's DSP and DSP Supervisor competency-based training and proficiency assessment processes. With specific questions that seek to assess the requirements in Compliance Indicators 49.2 and 49.3, the process produces data and information that is used to measure the successful achievement of an effective statewide core competency-based training program for DSPs and DSP Supervisors. HSAG's QSR reviewers received training on the new content requirements prior to beginning Review 3, SFY 2022. This training included specific instructions for determining yes/no responses and procedures to complete and submit a Health, Safety, and Wellbeing (HSW) alert for any "no" response on specific questions. The HSW alerts generated for these "no" responses go to the provider and to DBHDS. The revised process began in 11/2021 with the third round of QSR reviews and the first complete set of data from this round of reviews was provided by HSAG in the DBHDS Quality Service Review Aggregate Report dated 06/17/2022.

Based on analysis of the structure of the review tool content, and the implementation of the tool and data collection/reporting processes through QSR Review 3, this method of assessing competence of the DSP/DSP Supervisor workforce is much improved over the Commonwealth's previous processes. The data to measure achievement of the 95% threshold required at Compliance Indicator 49.4 is being drawn

from the HSW alerts generated by HSAG reviewers. The raw data from these HSW alerts is available for analysis. However, the Commonwealth has not yet determined the specific processes for analyzing the data and determining how the numerator and denominator will be calculated to measure the threshold for the Compliance Indicator. DBHDS staff report that the information from this 21st period study will be considered in making the final determinations about how the data from the HSW alerts will be utilized. This determination by DBHDS will impact the measurement of the threshold required at Compliance Indicator 49.4 and in other quality assurance oversight processes used to measure the effectiveness of the statewide core competency-based training curriculum.

The Compliance Indicator requirements assessed through the DBHDS Licensing Inspection process identified in Indicators 49.9, 49.10, 49.11, and 49.12 continue to be carried out consistently by DBHDS Licensing Specialists. The Office of Licensing Annual Checklist Compliance Determination Chart-2022 provides Licensing Specialists detailed instructions on what evidence must be assessed, how regulatory compliance is to be determined, and how non-compliance is to be documented in the annual licensing inspection corrective action plan documents generated from each inspection. Data related to the Licensing assessment of compliance with the regulations associated with the four Compliance Indicators identified above is recorded in the CONNECT data system. Provider-specific scoring for all licensed providers was made available to the consultant for review. DBHDS did not provide a process description document or data reliability and validity attestation statement for the CONNECT data used to determine if the 86% threshold requirement in Compliance Indicator 49.12 was met. Without that information, it was not possible to fully assess the data analysis and reporting processes.

DBHDS has continued its efforts to ensure that training and technical support is made available to providers in a variety of areas including but not limited to nursing/health services and behavioral services. Processes to accomplish this have been continued and refinements have been made to both structure and content of the initiatives. The Offices of Integrated Health and Provider Development continue their coordination of a multi-faceted support network for providers through newsletters, virtual and in-person training, health alerts, monthly nursing meetings, and quarterly provider roundtable meetings. Information from the ten sample providers interviewed as part of this study consistently praised the support provided by the Office of Integrated Health and specifically focused on the utility of the "Health Trends" newsletter and the quarterly provider roundtable meetings.

Conclusion:

The following table summarizes the recommended status of each Compliance Indicator in Sections V.H.1 and V.H.2 based on review of relevant documentary evidence, interviews with DBHDS, DMAS, and HSAG staff members, and interviews with ten providers across the Commonwealth:

V.H.1 Indicators	Status
49.1: 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
49.2: 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);	Not Met

V.H.1 Indicators	Status
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.	
49.3: 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
49.4: At least 95% of DSPs and their supervisors receive training and competency testing per DMAS regulation 12VAC30-122-180.	Not Met
49.5: 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
49.6: 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
49.7: 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

V.H.1 Indicators	Status
49.8: 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
49.9: 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
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
50.1: 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
50.2: 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
50.3: 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
49.1: 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.	The DBHDS initial DSP Orientation Training and Competencies Protocol issued in 03/2020 contains a detailed summary of the DD Waiver requirements for competency training, testing, and observation/ongoing competency assessment for all DSPs and DSP Supervisors providing direct services for waiver participants. Two additional modules addressing "Change of Status" and "Choking" were added to the Competency Protocol in 11/2021. A comprehensive online training program for DSP Supervisors is a part of the Orientation Training and Competencies Protocol. This online training is available through the Commonwealth of Virginia Learning	The current orientation and training protocol for DSPs and DSP Supervisors was made available to providers in 03/2020. Additional training modules addressing "Change in Mental Status" and "Choking" were added in 11/2021. The orientation and training protocol contains a comprehensive and detailed description of the training requirements and the provider's responsibility to carry out core competency training and competency assessment, including passing the DSP Competency Test at 80% or higher, within 180 days of hire and annually thereafter. The consultant reviewed training policies from ten randomly selected providers across the Commonwealth and conducted in-person interviews with those providers in which they described, in detail, how they have integrated the competency training and assessment requirements into their overall staff training program. Each training policy reviewed contained specific descriptions of the provider's processes for conducting initial and annual competency training, assessments, and re-assessments.	19th-Met 21st-Met

Compliance Indicator	Facts	Analysis	Conclusion
	Center virtual learning platform. The supervisor training is a self-study program that includes training modules entitled Enhancing Supervisor Skills, Enhancing Employee Performance, and Leadership Excellence Among Developmental Disabilities Supervisors. These online training modules also contain a competency test that the supervisor must pass to successfully complete the training.	DSP supervisors must complete online training and testing through the Commonwealth of Virginia Learning Center. This web-based application includes three self-study training modules. 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. These requirements were also addressed in each of the provider's policies reviewed as a part of the sample. Feedback from sample providers regarding the supervisory training modules was generally positive with most indicating that the structure and content of the training was helpful, especially for new supervisors.	
49.2: 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	Regulations at 12VAC30-122-180 (DMAS) address each of the seven requirements in this Compliance Indicator. These regulations went into effect on 03/31/2022. The DMAS Quality Management Review process does not include a sample size sufficient to generalize its results to the entire provider community. Consistent with requirements from Curative Action #10, the Commonwealth expanded the Quality Service Review process to incorporate review of the elements required from this Compliance Indicator. This revised	The Commonwealth codified the training and core competency requirements for DSPs and DSP Supervisors (including contracted staff) providing direct services in regulations that are found at 12 VAC 30-122-180. DMAS notified providers that these regulations became effective 05/01/2021. The regulations address 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 other support levels paid at a customized rate. The regulation also establishes requirements for training, competency testing, and initial and ongoing proficiency testing and verification for DSPs and DSP Supervisors. DMAS began review and determination of compliance with these revised regulations in 10/2021 reviewing information from the quarter 07/01/2021-09/30/2021. The DMAS Quality Monitoring Review (QMR) process does not have a sample size sufficient to generalize results to the entire provider community, does not include review of the provider's	19th-Not Met 21st- Not Met

Compliance Indicator	Facts	Analysis	Conclusion
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	process includes observations of DSPs and DSP Supervisors supporting individuals, interviews with DSPs and DSP Supervisors to obtain information relevant to an assessment of their competency to implement the individual's ISP fully and correctly, and record reviews including review of each sampled individual's ISP content to inform the review of DSP and DSP Supervisor competency to carry out the requirements in the ISP. The QSR record review process also includes assuring that documentation of the competency training and assessment process is on file in the DSP's/DSP Supervisor's personnel record. The process was initiated in the 3rd round of QSR reviews conducted from 11/2021-05/2022. QSR reviewers are required to submit a Health, Safety, and Wellbeing (HSW) alert to the provider and to DBHDS noting the specific staff member(s) determined not to be competent in one or more assessed areas. The Provider Data Summary-May 1, 2022 noted that there were 54 HSW alerts related to provider agency staff not meeting orientation training requirements out of 565 employee records reviewed. This Summary also noted there were 91 HSW alerts related to DSPs not	employee training policies, and does not include in-person assessment of DSP and DSP Supervisor competencies prescribed in this Compliance Indicator. Recognizing the concern about the small number of waiver providers reviewed through the QMR process during each 12-month period and the absence of face-to-face assessment of DSP competency to deliver services, the Commonwealth developed a curative action (Curative Action #10) approved by the parties through the Joint Filing of Agreement on Curative Action dated 10/29/2021. This Curative Action added specific in-person monitoring requirements and protocols to the Quality Services Review (QSR) process completed by the Health Services Advisory Group (HSAG). The stated outcome for this Curative Action is to "ensure that DSPs and DSP supervisors meet training and core competency requirements, including demonstration of competencies." The QSR elements specific to this Curative Action include review of personnel/training records for a sample of provider staff, review of sample individuals' ISPs to determine staff training needs; observation of DSPs carrying out the ISP requirements and assessment of their competence to do so; interviews with DSPs/Supervisors to ascertain their level of understanding of the ISP content, their assessment of how effective the ISP is in addressing the identified content, and their input about whether their concerns are being adequately addressed; and observation of DSP Supervisors demonstrating competency in providing the services they are coaching and supervising. Review of the QSR process descriptions and interviews with HSAG staff, Katherine Means, and Eric Williams confirmed that the process in place addresses each of the actions listed in	

Compliance Indicator	Facts	Analysis	Conclusion
individual's status.	meeting competency training requirements out of 1,183 staff observed. The process to aggregate and analyze the data to measure achievement of the outcomes required in the Compliance Indicator and in Curative Action #10 has not yet been finalized. Data to inform whether a sufficient number of DSPs and supervisors were studied to provide a full and complete analysis and to determine whether the requirements of this Compliance Indicator and the related Curative Actions have been met. The Curative Action includes a list of actions to determine whether the DSPs and DSP supervisors on-duty during the QSR reviews have met the training and core competency requirements contained in DMAS regulation 12VAC30-122-180.	Curative Action #10. QSR Reviewers are required to review the personnel records for a sample of DSPs and DSP Supervisors including the content of the Competency Checklist that documents the DSP Supervisor's assessment and verification that the DSP has demonstrated competence in each of the areas outlined in this Compliance Indicator. If the QSR Reviewer determines the Competency Checklist is complete and current, he/she would answer "yes" to the following question in the QSR Review: *How many employee records in the sample have proof of competency-based training?* If the answer to this question is "no", the QSR Reviewer completes and submits a Health, Safety and Wellbeing (HSW) alert noting that the employee record reviewed was without proof of competency-based training. Both the provider and DBHDS receive notice of this finding specific to each employee for which there was a "no" response. Additionally, the QSR Reviewer answers a series of questions that address observation and assessment of DSP and DSP Supervisor competence in areas addressed in the individual's ISP including health risks, positive behavior supports, effective communication, and community integration and social inclusion. This reviewer verified that the process was followed and that these questions address the specific actions included in the Curative Action #10. These actions include review of the individual's ISP, observation of the provision of services and supports, observation and assessment of the staff's understanding of the person's needs, and observation and interview of staff to determine their understanding of the content and requirements of the individual's ISP. The emphasis of the QSR questions is on health risks and positive behavioral support. Following are the specific questions answered by the QSR Reviewer from their observations and interviews: • *For individuals with behavior support plans, were staff addressing*	

Compliance Indicator	Facts	Analysis	Conclusion
		behaviors per the BSP? • *Were staff adhering to medical and behavioral protocols as outlined in the plan?* • *Did staff appear to understand the person's support needs?* • *Did the staff demonstrate competence in supporting the individual?* • *Was staff able to describe the outcomes being worked on in this environment?* • *Could the staff describe the medical support needs of the individual?* • *Were staff familiar with medical protocols to support the person?* • *Could the staff describe behavioral support needs?* • *Were staff familiar with behavior protocols to support the person?* • *Does the staff know what medications the person is taking?* • *Can the staff list the most common side effectives of the medications the person is on?* The QSR process requires that if the reviewer determines, from the observations and interviews, that the answer to any of these questions is "no", the Reviewer must complete and submit an HSW alert noting the name of the employee for whom the competency was not verified. The QSR reviewer is to notify the provider and DBHDS of this finding specific to each employee for which there was a "no" response. The plan is for the Commonwealth to use the data regarding the number of HSW alerts received to calculate the percentage compliance requirements at 49.4 below. In summary, the Commonwealth has established regulations that require DSPs and DSP Supervisors, including contracted staff, providing direct services to meet specific training and core competency requirements including demonstration of competencies specific to health and safety within 180 days of hire. The process for Virginia to assess whether these regulatory requirements are consistently met was recently modified through an agreed upon Curative Action that integrated this	

Compliance Indicator	Facts	Analysis	Conclusion
		assessment process for staff on-duty during QSR reviews. The QSR procedures address the functional requirements of this Compliance Indicator for a subset of the DSPs and DSP supervisors who provide services under the Agreement. The Curative Action #10 demonstrates significant efforts to improve the substantive review and assessment of the functional requirements of this Indicator. However, there remains a question regarding whether the sample size and selection process is sufficient to generalize to all DSPs and DSP supervisors that provide waiver-funded services. The Commonwealth should provide sufficient description in its documentation during the 23rd period review to substantiate that the sample size and its random selection in the QSR review process is sufficient to generalize to all DSPs and DSP Supervisor that provide waiver-funded services. While the QSR review process initiated during the 3rd round appears sound and the Health, Safety and Wellbeing alert process, when consistently implemented, ensures timely notification of the provider and DBHDS regarding any identified competency concern, DBHDS has not yet determined whether its QSR assessment process is sufficient to allow data to be aggregated and analyzed to measure achievement of the outcomes required in this Compliance Indicator for DSPs and their supervisors. Without this critical step in the process being implemented, sufficient evidence is not available to determine that the Commonwealth has fully met the performance requirements of this Indicator.	
49.3: DSPs and DSP Supervisors who have not yet completed training and competency requirements per DMAS regulation 12VAC30-122-	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-	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	19th-Not Met 21st- Not Met

Compliance Indicator	Facts	Analysis	Conclusion
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.	approved, objective, standardized] test. 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 and guidance, of qualified staff until competence is observed and documented. DBHDS's 3rd round of QSRs implemented a standardized process to assess whether the requirements in this Compliance Indicator and the actions delineated in Curative Action #10 have been achieved. While not a specific requirement in the curative action, this reviewer determined that the QSR assessment of this element does not require the QSR reviewer to send an HSW alert to the provider and to DBHDS to notify them of the identified area of concern.	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 regulation at 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 and guidance, of qualified staff until competence is observed and documented." QSR Reviewers are required to assess whether, during the QSR observation, there were new staff supporting the individual who have not yet passed the competency assessment test at 80% or higher and if so, whether those new staff were being supervised by someone who has successfully passed the competency test. The competency test includes assessment of competencies related to health and safety (Competency 3). Each of the 10 sample providers that was interviewed as a part of this study was able fully describe the processes they employ to assure that staff who have not yet passed the competency test at 80% or higher are supervised by staff who have achieved required competencies. Sampled providers interviewed indicated they did not allow staff to work directly with individuals until this test was passed. However, the processes they described were not specifically noted in nine of the ten sampled providers' staff training policies and there was no documentation to verify whether supervision was occurring if the employee worked with an individual unsupervised prior to passing the test. Only one provider's policy specifically	

Compliance Indicator	Facts	Analysis	Conclusion
		referenced supervision prior to achieving "competence". In summary, the QSR process revisions prior to initiation of the Round 3 QSRs incorporated assessment of whether the provider assures that 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. This process change meets the requirements in Curative Action #10. Responses are recorded by the QSR Reviewer, but the reviewer is not currently required to issue an HSW alert if the answer is "no". To assure notifications have been made to the provider and to DBHDS for any "no" response to this specific question on the QSR tool, an additional instruction should be provided to the QSR reviewer to submit an HSW alert following the same instructions listed in the process description for Compliance Indicator 49.2 above.	
49.4: At least 95% of DSPs and their supervisors receive training and competency testing per DMAS regulation 12VAC30-122-180.	12VAC30-122-180 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 observations and verification and document this verification on the competency checklist within 180 days from date of hire.	The Commonwealth modified methodology to measure the percentage compliance with this indicator, as stipulated in Curative Action #10 which was approved by the parties on 10/29/2021, using data regarding the number of HSW alerts issued in response to specific questions from the QSR review process outlined for Compliance Indicator 49.2 above. Using the current methodology for calculating the percentage of DSPs and their supervisors who received training and testing, neither of the elements measured and reported in the most recent Provider Data Summary achieved the required 95% compliance threshold: • Percentage of provider agency staff meeting provider orientation and training requirements – 511/565 (90.4%) • Percentage of provider agency DSPs meeting competency	19th-Not Met 21st- Not Met

Compliance Indicator	Facts	Analysis	Conclusion
	Beginning with the 3rd round of Quality Services (QSR) reviews in 11/2021, assessment of this measure was added to the Quality Services Review process conducted by HSAG. The QSR assessment process, outlined under Compliance Indicator 49.2 above, contains all required elements and measurement of compliance is accomplished through data collection and analysis from the Health, Safety, and Wellbeing (HSW) alerts sent by the QSR reviewer when a specific employee is determined not competent with any of the competencies assessed in the QSR tool.	training requirements - 1092/1183 (92.3%) While a process document related to this data collection, analysis, and reporting process was provided, discussion with DBHDS staff confirmed that the process was still in development and that changes to this process were needed to assure that the data is being analyzed correctly to measure whether the requirements of this Compliance Indicator are met. Of specific concern was the determination of what would be counted in the denominator for this calculation to accurately quantify the number of DSPs and DSP Supervisors. The Commonwealth has not fully developed and implemented an assessment, data analysis and reporting methodology that accurately measures the requirement that 95% of DSPs and DSP supervisors have received the required training and competency testing required by this Compliance Indicator. There was no attestation statement provided for this measure. DBHDS staff stated that the process continues to be evaluated and revised and will be finalized after receipt and review of the results of this 21st period study.	
49.5: 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	The Office of Integrated Health continues to make available training, technical assistance, online resources, newsletters, and electronic updates on information relevant to nurses and behavioral interventionists. This information is made available through the DBHDS website, through newsletters, health alerts, monthly nurse meetings, and quarterly provider roundtable meetings.	The DBHDS Office of Integrated Health has continued to make available a variety of resources and technical assistance for nurses, behavior interventionists, and other provider staff regarding best practices in provision of services and supports for individuals with developmental disabilities. An extensive array of resources for health services and behavioral supports are provided including the monthly "Health Trends" newsletter; periodic health and safety alerts on topics including characteristics of persons with intellectual and developmental disabilities, anaphylaxis, aspiration pneumonia, leading causes of fatality, polypharmacy, and measurement of vital signs.	19th-Met 21st-Met

Compliance Indicator	Facts	Analysis	Conclusion
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.	DBHDS has significantly expanded resources and technical assistance for providers related to provision of effective behavioral supports including initiation of a new section on the DBHDS website entitled "Behavioral Services". This new section on the website contains information on a broad array of topics relevant to behavioral services and supports. Providers who were a part of this study consistently shared positive feedback on the availability and usefulness of the information provided through the DBHDS Office of Integrated Health, specifically noting guidance and assistance in addressing health-related questions.	There are also caregiver training opportunities addressing a variety of topics specific to the roles and responsibilities of DSPs and other first-line caregivers in the provision of hands-on services. The Office of Integrated Health facilitates virtual regional nurse meetings monthly. Topics discussed in these meetings focus on items of general interest applicable across the Commonwealth and specific questions or issues identified from participants from each region. Continuing Nurse Education credits are provided for specific topic presentations. DBHDS has significantly expanded resources and technical assistance for providers related to provision of effective behavioral supports. A new section on the DBHDS website entitled "Behavioral Services" includes links to monthly newsletters, instructions for providers on how to locate a behaviorist, available trainings, links to several journals and other professional publications, and other resources for behaviorists. Following release of the DBHDS/DMAS Practice Guidelines for Behavior Support Plans, DBHDS has provided several training and information sharing opportunities including a two-part training on graphical displays and visual analysis in behavioral services provided in 09/2022 in partnership with the University of Cincinnati. This training was recorded and is available through the DBHDS YouTube channel. DBHDS also developed and began use of the Behavior Support Plan Adherence Review Instrument (BSPARI) to strengthen and standardize quality assurance review of behavior support plans. Provider training on use of the BSPARI was conducted in 01/2022 with more than 180 attendees. By 08/2022, over 200 BSPARI reviews had been completed with analysis of the results presented in a training with more than 75 attendees. Providers interviewed as a part of this study consistently shared positive feedback about the resources and technical assistance	

Compliance Indicator	Facts	Analysis	Conclusion
		made available to them with particularly positive emphasis on health-related resources. Each of the ten providers in the sample shared examples of information and resources from the DBHDS Office of Integrated Health that had been helpful, and all shared an appreciation for the information in the "Health Trends" newsletter noting its relevance, regular publication, and succinct presentation of useful information. The newsletter was described as a very helpful format during the stressful times that providers have experienced over the past two years due to the COVID pandemic.	
49.6: 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.	DMAS transportation fee-for-service and managed care contract requirements are established in the "VA Transportation Provider Agreement 2021" between Modivcare Solutions, LLC and the contracted transportation provider agency. The most recent iteration of these contract documents is dated 03/05/2021 and there have been no changes in the requirements since the 19th period study. These requirements state that all drivers, attendants, taxi drivers, and volunteer drivers must pass a Passenger Service and Safety 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. Quality assurance reviews of transportation providers are performed	DMAS established a contract with LogistiCare Solutions, LLC (renamed ModivCare Solutions, LLC), in January 2018 to provide non-emergency medical transportation brokerage services. DMAS requires, through this contract, that transportation drivers must meet DMAS-specified training requirements as outlined in the contract. These requirements have not changed since the contract was initially executed. The contract also contains provisions for failure to meet requirements including those related to training. This review verified that both Modivcare (Formerly LogistiCare) and the DMAS Transportation Management Services Unit have completed oversight reviews and identified violations or deficiencies. Evidence that DMAS monitors whether these transportation providers fulfill contract requirements includes that DMAS has imposed payment reductions resulting from non-compliance throughout the term of the contract. To date, none of those payment reductions were specifically related to non-compliance with the training requirements.	19th-Met 21st-Met

Compliance Indicator	Facts	Analysis	Conclusion
	by Modivcare (Formerly LogistiCare) and by the DMAS Transportation Management Services Unit and identified violations or deficiencies may result in liquidated damages being imposed. There have been no liquidated damages imposed related to driver training during the past year.		
49.7: 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.	The DBHDS Office of Integrated Health continues to provide a wide array of information, training, and technical assistance to community nurses. Information is provided through the monthly "Health Trends" newsletter, periodic health and safety alerts, monthly regional nurse meetings conducted virtually, and an annual Statewide Nursing Conference. Technical assistance is provided upon request or as identified from specific health-related licensing violations. Based on feedback from sampled providers, the technical assistance is both timely and useful for nurses and others providing or directing the delivery of services and supports.	The DBHDS Office of Integrated Health has continued to make available a variety of resources and technical assistance for nurses and other provider staff regarding best practices in provision of services and supports for individuals with developmental disabilities. An extensive array of resources for health services is available including the monthly "Health Trends" newsletter; periodic health and safety alerts on topics including a general overview of characteristics of persons with intellectual and developmental disabilities, anaphylaxis, aspiration pneumonia, leading causes of fatality, polypharmacy, and measurement of vital signs; and caregiver training opportunities addressing a variety of topics specific to the roles and responsibilities of DSPs and other first-line caregivers. The Office of Integrated Health facilitates monthly regional nurse meetings which are conducted virtually. Topics discussed in these meetings focus on general interest items applicable across the Commonwealth and specific questions or issues identified from participants from each region. Continuing Nurse Education credits are provided for specific topic presentations. The Office of Integrated Health also sponsors an annual Statewide Nursing Conference. The third annual conference was held on 10/13/2022 in Virginia Beach. The theme for the 2022 conference was "Risk Reduction and Increasing Access for Individuals with Intellectual and Developmental	19th-Met 21st-Met

Compliance Indicator	Facts	Analysis	Conclusion
		Disabilities." The ten providers in the study sample each shared positive input regarding health-related supports provided by the Office of Integrated Health. They spoke of the usefulness of these supports for nurses and for other staff who are providing direct services or supervising or directing the provision of these services.	
49.8: 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	12VAC35-105-440 (DBHDS Licensing) requires that "New employees, contractors, volunteers, and students shall be oriented commensurate with their function or job-specific responsibilities within 15 business days. DBHDS licensing specialists have detailed instructions, outlined in the Office of Licensing Annual Checklist Compliance Determination Chart-2022, that guide them in their assessment of compliance with this regulation. Each of the ten providers selected for the sample in this study had a current training policy that included the requirements at 12VAC35-105-440 and each was able to articulate, during the interview, how they operationalize and document their compliance with these requirements for new employee orientation.	The DBHDS Licensing regulation at 12VAC35-105-440 requires that 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: 1. Objectives and philosophy of the provider; 2. Practices of confidentiality including access, duplication, and dissemination of any portion of an individual's record; 3. Practices that assure an individual's rights including orientation to human rights regulations; 4. Applicable personnel policies; 5. Emergency preparedness procedures; 6. Person-centeredness; 7. Infection control practices and measures; 8. Other policies and procedures that apply to specific positions and specific duties and responsibilities; and 9. 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 DBHDS in accordance with this chapter. The Office of Licensing Annual Checklist Compliance Determination Chart-2022 instructs licensing specialists, in relation to the procedures for assessing compliance with this	19th-Met 21st-Met

Compliance Indicator	Facts	Analysis	Conclusion
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.		regulation, that this requirement must be reviewed for all services including case management. Licensing Specialists are required to review the provider's policy outlining the content of their new employee orientation and they must also review a sample of personnel records containing documentation that the employee completed the required new employee orientation within 15 business days of hire. The provider is cited for non-compliance at 12VAC35-105-440 if the documentation of the orientation does not contain evidence that each required element of the orientation was addressed during the new employee orientation. During licensing inspections conducted during CY2022, Licensing Specialists identified that 660/779 (84.94%) licensed providers provided documentation of successful completion of new employee orientation that includes all elements required at 12VAC35-105-450. Each of the ten providers selected for the sample for this study provided a copy of their training policy for review. The requirements at 12VAC35-105-440 were addressed in each of the policies provided. During the provider interviews, each provided a specific description of how they conduct and document required training within 15 days of employment and examples of the documentation that each of the topics was covered in the orientation.	
49.9: 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	12VAC35-105-665.D (DBHDS Licensing) 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 waiver participant's current ISP, including a waiver participant's detailed health and safety protocols."	The DBHDS Licensing regulation at 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 waiver participant's current ISP, including a waiver participant's detailed health and safety protocols." The Office of Licensing Annual Checklist Compliance Determination Chart-2022 instructs licensing specialists, in	19th-Met 21st-Met

Compliance Indicator	Facts	Analysis	Conclusion
in each individual's current ISP, including an individual's detailed health and safety protocols.	The Office of Licensing Annual Checklist Compliance Determination Chart-2022 instructs licensing specialists, in relation to the procedures for assessing compliance with this regulation, to review documentary evidence that staff received training on waiver participants' ISPs, including health and safety protocols and that the staff's competency was assessed as part of this training.	relation to the procedures for assessing compliance with this regulation, to review documentary evidence that staff received training on waiver participants' ISPs, including health and safety protocols and that the staff's competency was assessed as part of this training. The licensing specialist is also instructed to determine if there was additional staff training provided in response to a change in status that resulted in a modification to the waiver participant's ISP. Each of the ten providers selected for the sample for this study provided a specific description of how they provide training to DSPs on each individual's ISP during initial orientation and at any time when the content of the ISP changes. Their descriptions were sufficiently specific to verify an acceptable process was being employed to assure this critical training is occurring. The requirement to provide training on ISP content was addressed in each provider's policy.	
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.	The Commonwealth has established a series of requirements for all provider settings where medications must be administered by someone other than the individual or his/her family member to ensure that persons who are responsible for administration of medications receive the 32-hour mandated training and competency assessment prior to administering any medications and annual retraining on these requirements. 18VAC90-21 (Virginia Board of Nursing) establishes requirements for a 32-hour classroom instruction with	The Commonwealth has established regulations at 18VAC90-21 under the Virginia Board of Nursing that establish the content, structure, and process for certification of non-licensed persons to administer medications. §30 of those regulations establishes content requirements for the 32-hour classroom instruction and practice training and §40 requires that each student shall pass a written and practical examination at the conclusion of the training that measures minimum competency in medication administration. For providers of services licensed by DBHDS, the licensing regulation at 12VAC35-105-770 includes two sections relevant to this compliance indicator. §A.4 requires the provider to implement written policies addressing employees or contractors who are authorized to administer medication and training requirements for administration of medication. §B requires that	19th-Met 21st-Met

Compliance Indicator	Facts	Analysis	Conclusion
	competency assessment for any individual who is being certified to administer medications. The regulation also requires that each student shall pass a written and practical examination at the conclusion of the training that measures minimum competency in medication administration. 12VAC35-105-770 (DBHDS Licensing) requires providers to implement written policies addressing employees or contractors who are authorized to administer medications and training requirements for these individuals. The regulation also requires that medications may only be administered by an individual who has successfully completed this 32-hour training and competency assessment. The DBHDS 32-hour medication aid training requires competency assessment and demonstration of competency to administer medications in accordance with the requirements of the Board of Nursing at 12VAC90-21. For any providers not required to be licensed by DBHDS, the Virginia Board of Nursing has approved competency-based Medication Aide training curricula to be used in various settings	medications be administered only by persons who are authorized to do so by state law. Neither of these licensing requirements specifically state 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 requires competency assessment and demonstration of competency to administer medications in accordance with the requirements of the Board of Nursing at 12VAC90-21 referenced above. Licensing regulations at 12VAC35-105-450 require 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 and 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. The Virginia Board of Nursing has approved competency-based Medication Aide training curricula to be used in various settings including programs licensed/regulated by DBHDS and other settings including Assisted Living Facilities, Adult Day Care Centers, and Children's Residential Facilities licensed by the Virginia Department of Social Services. If medication administration is a service provided by a non-licensed entity, the Commonwealth has established regulations	

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	including Assisted Living Facilities, Adult Day Care Centers, and Children's Residential Facilities licensed by the Virginia Department of Social Services.	at 18VAC90-19-230-280 that define specific requirements and procedures for nurse delegation of specific tasks to unlicensed persons. Medication administration is included within the scope of this delegation authority. These regulations require that a registered nurse in Virginia must assess the training, skills, and experience of the unlicensed person and verify the competency of the unlicensed person to determine which tasks are appropriate for that unlicensed person and the method of supervision required. DBHDS has placed information about the medication management initial and ongoing training requirements in the Centralized Training for Providers-Required Training section of the Provider Development webpage on the DBHDS website. This information includes specific reference to in-service training to employees who will be responsible for administering medications and that this training "must be completed prior to an employee administering medications." This section also references training curriculums approved by the Virginia Board of Nursing, a link to DBHDS-specific medication administration training, and information on how to locate providers of the required 32-hour initial medication administration certification and annual recertification training. All ten providers interviewed as a part of this study provided detailed descriptions of their requirements and procedures to ensure that every staff member who is responsible for medication administration completes the mandatory 32-hour training course and the required retraining. In summary, the Commonwealth has established a series of requirements to ensure that persons who are responsible for administration of medications receive the 32-hour mandated	

Compliance Indicator	Facts	Analysis	Conclusion
		training and competency assessment prior to administering any medications and annual retraining on these requirements. Requirements are in place, as described above, for all settings where medication administration is a part of the service array for individuals receiving services.	
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.	12VAC30-122-120.A.21 (DMAS) establishes a regulatory requirement with wording identical to the wording in this Compliance Indicator; however, compliance with this regulation is not specifically assessed in the DMAS Quality Monitoring Review process. 12VAC35-105-810 (DBHDS Licensing) requires that providers ensure behavior treatment plans are "developed, implemented, and monitored by employees or contractors trained in behavioral treatment." 12VAC35-115-110.C.10 (DBHDS Human Rights) 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."	The DMAS regulation at 12VAC30-122-120.A.21 establishes a regulatory requirement with wording identical to the wording in this Compliance Indicator. However, compliance with this regulation is not specifically assessed in the DMAS Quality Monitoring Review process. 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. Reviewer's Note: The monitoring process utilized in the annual licensing inspection is evaluated at Compliance Indicator 49.2. 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	19th-Met 21st-Met

Compliance Indicator	Facts	Analysis	Conclusion
		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 DSP's/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.	
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	12VAC35-105-450 (DBHDS Licensing) requires the provider to provide training and development opportunities for employees to enable them to support the individuals receiving services and to carry out their job responsibilities and that the provider must have a training policy that specifies the frequency of retraining on serious incident reporting, medication administration, behavior intervention, emergency preparedness, and infection control, to include flu epidemics. 12VAC35-105-50, 100, 110, and 115 (DBHDS Licensing) describes regulatory enforcement action options to address identified serious non-compliance, patterns of non-compliance, and/or non-compliance that is identified repeatedly. The Office of Licensing Annual Checklist Compliance Determination Chart-2022 provides detailed guidance	12VAC35-105-450 (DBHDS Licensing) 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 that 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." Additionally, 12VAC35-105-50, 100, 110, and 115 prescribes negative actions and sanctions that can be taken with providers with significant or re-occurring citations. The Office of Licensing Annual Checklist Compliance Determination Chart-2022 provides detailed guidance to Licensing Specialists on how to assess compliance through review of the provider's training policy to ensure it contains all the required elements and review of training records to verify that each DSP/Supervisor in the sample has documentation of the required training. DBHDS produced a provider-specific data summary that details compliance determinations for 12VAC35-105-450 for 779 licensed providers who were inspected in CY2022. Compliance with the requirements at 12VAC35-105-450 was not determined for 2/779 providers. Of the 777 licensing	19th-Not Met 21st-Not Met

Compliance Indicator	Facts	Analysis	Conclusion
fail to comply with training requirements required by regulation.	to Licensing Specialists on how to assess compliance through review of the provider's training policy to ensure it contains all the required elements and review of training records to verify that each DSP/Supervisor in the sample has documentation of the required training. Although a structured assessment process is a part of the annual licensing inspection, and data related to the findings of this assessment are entered into the CONNECT system by licensing specialists, DBHDS did not provide a process document describing the process for data compilation and assessment, nor did it provide an attestation statement regarding the data's validity and reliability. Additionally, the data that was provided by DBHDS specific to measurement of compliance with the threshold in this Compliance Indicator identified that the required threshold was not met during the compliance measurement period.	inspections completed where a compliance determination was made, 84.9% (660) were found compliant and 15.1% (117) were found non-compliant. The compliance calculations were independently verified by the consultant using provider specific compliance determinations for 12VAC35-105-450 contained in the data table provided by DBHDS. Based on this data, the compliance threshold of 86% was not met in CY2022. DBHDS did not provide a process document, or an attestation statement related to the data collection, analysis and reporting requirements associated with this indicator stating that a full evaluation and verification that the CONNECT data system produces accurate and reliable data had not yet been completed.	
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	Both DBHDS and DMAS have continued to refine their processes for aggregation and presentation of relevant findings from their respective regulatory oversight processes. The agencies have jointly created a	DMAS and DBHDS have continued to refine and improve the process for sharing information about DMAS regulatory findings specific to staff qualifications and competencies through quarterly provider roundtable meetings. There is an organized and documented process for collaborative inter-agency data gathering, identification of relevant trends and patterns, and quarterly roundtable presentation agenda development with specified assignments and timelines for all	19th-Met 21st-Met

Compliance Indicator	Facts	Analysis	Conclusion
available to providers through quarterly provider roundtables.	process document that describes how data and information is compiled for presentation in quarterly provider roundtable meetings and review of information from the last four of these meetings reflects that the process is being consistently followed. Providers interviewed as a part of this study shared positive input about the usefulness of these meetings and expressed appreciation for their continuation.	individuals involved in the process. The quarterly roundtable meetings are led by the Community Resource Consultants who are ultimately responsible for ensuring that all required content is incorporated into the meeting agenda. Providers are given sufficient notice of the dates and times of the meetings which, since the advent of COVID restrictions, are conducted virtually. Review of the PowerPoint presentations for quarterly roundtable meetings held on 10/26/2021, 01/25/2022, 04/27/2022, and 07/27/2022 evidenced consistent adherence to the content requirements documented in the interagency process description document. Each contained specific information about DBHDS and DMAS regulatory findings and discussion of relevant trends and patterns of citations in all areas including those related to staff qualifications and competencies. A quarterly roundtable meeting was held on 10/26/2022 and an agenda for this meeting was sent to providers via the Provider ListServ on 10/17/2022; however, the results of this meeting were not available in time for inclusion in this analysis. The 10 sample providers interviewed for this study provided consistently positive assessments of the consistency and usefulness of the quarterly provider roundtable meetings. While there was some divergence of opinion as to the meetings being held in person or virtually, each of the 10 sample providers agreed that participation in the meetings was significantly easier and the number of participants appeared larger using the virtual format.	
50.1: DSP Supervisors are responsible	12VAC30-122-180 (DMAS) establishes specific requirements for DSP	The regulatory requirements at 12VAC30-122-180 establish specific requirements for DSP supervisors to train and assess	19th-Met

Compliance Indicator	Facts	Analysis	Conclusion
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.	supervisors to train and assess competency of DSPs working under their supervision. DBHDS Provider Development developed and implemented a 3-module online training curriculum for supervisors on 07/01/2020 and made it available to providers through the Commonwealth of Virginia Learning Center (COVLC). The format and content of the training curriculum modules has remained consistent since implementation in 07/2020. Data from the Provider Data Summary for SFY 2021-22 dated 05/01/2022 notes that 212 supervisors successfully completed the supervisory training modules from 05/01/2021-10/31/2021 and 381 supervisors successfully completed these training modules from 11/01/2021-04/30/2022. Each of the ten providers in the sample for this study included specific reference to these requirements in their employee training policies.	competency of DSPs working under their supervision. These regulations apply to providers of agency-directed personal assistance services, agency-directed companion services, agency-directed respite services, center-based crisis supports, crisis support services, community engagement services, community coaching services, group day services, group home residential services, independent living support services, individual and group supported employment, in-home support services, sponsored residential services, supported living residential services, and workplace assistance programs. DBHDS Provider Development developed and implemented a 3-module online training curriculum for supervisors on 07/01/2020 and made it available to providers through the Commonwealth of Virginia Learning Center (COVLC). The training addresses supervisors' responsibilities for ensuring DSP training, testing, and competency requirements that are included in each of the waivers. The format and content of the training curriculum modules has remained consistent since implementation in 07/2020. The system tracks each supervisor's completion of the training and provides a certificate of completion that can be retained in the supervisor's personnel file. DMAS QMR reviewers review these certificates of completion as a part of their sample review of provider compliance. Each of the 10 providers interviewed in the sample for this study included reference to this supervisory training in their employee training policy and each was able to describe the procedures they follow to ensure that their supervisory staff successfully complete the required training modules, obtain the certificate of completion, and maintain a copy of the certificate of completion in the supervisor's personnel file.	21st-Met

Compliance Indicator	Facts	Analysis	Conclusion
		Data from the Provider Data Summary for SFY 2021-22 dated 05/01/2022 notes that 212 supervisors successfully completed the supervisory training modules from 05/01/2021-10/31/2021 and 381 supervisors successfully completed these training modules from 11/01/2021-04/30/2022. DBHDS does not have specific data or an estimate of how many DSP Supervisors are working in the system and without this reference data cannot calculate or estimate the percentage of supervisors who have successfully completed the modules.	
50.2: 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;	12VAC30-122-180 (DMAS) requires DSPs and DSP Supervisors to complete a DMAS-approved orientation training and pass a DMAS-approved objective, standardized test of knowledge, skills and abilities at 80% or higher. The 3-module online training curriculum for supervisors that is accessed through the Commonwealth of Virginia Learning Center (COVLC) addresses each of the elements required by this compliance indicator. The format and content of these training modules has remained consistent since implementation in 07/2020.	DBHDS Provider Development developed and implemented a 3-module online training curriculum for supervisors on 07/01/2020 and made it available to providers through the Commonwealth of Virginia Learning Center (COVLC). The training addresses supervisors' responsibilities for ensuring DSP training, testing, and competency requirements that are included in 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. The format and content of these training modules has remained consistent since implementation in 07/2020. The system tracks each supervisor's completion of the training and provides a certificate of completion that can be retained in the supervisor's personnel file. DMAS QMR reviewers review these certificates of completion as a part of their sample review of provider compliance.	19th-Met 21st-Met

Compliance Indicator	Facts	Analysis	Conclusion
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.			
50.3: 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.	DBHDS continues to provide 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 circumstances and to assist these entities to develop workable solutions to meet their unique needs. The training and education activities that each of these offices has provided during the past year continues to have broad application to the diverse provider community. They continue to be provided through virtual trainings, some in-person trainings, and monthly and quarterly provider or discipline-specific meetings.	The Office of Integrated Health publishes monthly Health and Safety Alerts and a monthly Health Trends newsletter. They facilitate monthly Regional Nurse Meetings and caregiver training sessions via Zoom addressing topics relevant to direct supports by caregivers. They operate a mobile rehabilitation engineering team that provides onsite durable medical equipment repairs, safety assessments and pressure washing services for providers across the state. They provide consultation and technical assistance related to dental services and consultation and technical assistance resources provided by the OIH Community Nursing Team. Other OIH training resources that are available through their website include information on choking, falls, urinary tract infections, vaccinations, infection control, medication administration, the importance of annual physicals, and risk awareness tools including information on risk management planning. Quarterly Roundtable and Support Coordinator/Case Manager meetings are led by Community Resource Consultants. Since the advent of COVID restrictions, the quarterly roundtable meetings are conducted virtually. A review of the PowerPoint presentations for quarterly meetings held on 10/26/2021, 01/25/2022, 04/27/2022, and	19th-Met 21st-Met

Compliance Indicator	Facts	Analysis	Conclusion
	DBHDS continues to support its Centralized Training for Providers website that contains links to and descriptions of required training, recommended training, and resources for training. This website is available to all providers.	07/27/2022 included a variety of support and coaching resources to enable and assist providers in improving service delivery. DBHDS has a webpage dedicated to information relevant to the provision of support coordination/case management. This webpage contains training modules available through the COVLC website; a link to the most current iteration of the DD Service Coordination Handbook (12/20/2021); information on Enhanced Case Management; links to the Crisis Risk Assessment Tool, Onsite Visit Tool, and Risk Awareness Tool; and Housing Resources. Beginning in 06/2020, DBHDS Provider Development continues to make information and reference materials available to providers through the Centralized Provider Training section on the DBHDS website. The website contains information on how to become a provider; links to the Virginia Provider Data Summary reports; information about jump-start funding and shared living options; a description of the purpose and functions of the Regional Support Teams and how to submit a referral for assistance; guidance on ISP development including templates and training; and contact information for Community Resource Consultants and other Provider Development staff. The DSP and Supervisor Orientation Training and Competencies section of the Provider Development website includes information about DSP Orientation and Training Competencies; Regulatory Requirements, DSP Orientation Supplemental Materials relating to training competencies for choking and change in mental status, Medication Management initial and ongoing training requirements, Person-Centered	

Compliance Indicator	Facts	Analysis	Conclusion
		Practices training resources, and a link to training on the COVLC training site related to Independent Housing. The 10 sample providers interviewed for this study provided consistently positive assessments of the consistency and usefulness of the provider roundtable meetings. While there was some divergence of opinion as to the meetings being held in person or virtually, each of the 10 sample providers interviewed agreed that participation in the meetings was significantly easier and the number of participants appeared larger using the virtual format. Sample providers also shared consistent positive feedback on support, coaching, and technical assistance provided by the Office of Integrated Health via their webpage, through the Community Resource Consultants, the Regional Support Teams, the Community Nursing Team, and the Medical Rehabilitation Resource Team.	

Recommendations

1. 49.2 - The Commonwealth should provide sufficient description in its documentation during the 23rd period review to substantiate that the QSR review process utilizes a sample size and random selection process that is sufficient to generalize its findings to all DSPs and DSP Supervisor that provide waiver-funded services.

2. 49.3 – To assure notifications have been made to the provider and to DBHDS for any "no" response to the question relating to whether an employee who has not yet been found competent in a required skill, an additional instruction should be provided to the QSR reviewer to submit an HSW alert if the answer to the question is "no". This will also provide data for use in assessing compliance with Compliance Indicator 49.4.

3. 49.4 - The specific process for how data from the QSR HSW alerts is to be used to calculate the numerator and denominator for Compliance Indicator 49.4 should be finalized and a more detailed process description document, separate from the Provider Data Summary processes, developed to memorialize this process for consistent ongoing implementation.

4. 49.12 – Data validation for the CONNECT system should be completed to ensure the accuracy and reliability of data related to the compliance determinations made by Licensing Specialists and to allow a full and accurate assessment of whether the requirements at Compliance Indicator 49.12 are met.

5. General – DBHDS and DMAS should implement their plans for a coordinated scheduling system for all provider reviews conducted by DMAS, DBHDS, and HSAG, and to develop and implement a repository for submission of required reference documents to lessen the burden of document scanning and submission and to help assure that providers are not having reviews near each other throughout the year.

6. General – DBHDS should consider some further categorization of information sent out through the Provider ListServe to provide some clear identification of critical information items and differentiate those from routine information sharing items.

7. General – The Office of Licensing should consider developing additional training for providers on content requirements for provider policy statements focusing on the need to assure that policies include specific information about the processes employed by the provider to carry out the policy requirements. This has been an emphasis in Office of Licensing training in the past However, when reviewing the employee training policies for this period's study, the providers interviewed consistently identified this as a consistent concern.

Attachment A: Interviews

V.H.1-V.H.2 (Provider Training Study)

Staff Interviews:

1. Ann Bevan, DMAS
2. Jason Perkins, DMAS
3. Threnodiez Baugh, DMAS
4. Eric Williams, Director of Provider Development, DBHDS
5. Heather Norton, Deputy Commissioner, Developmental Services, DBHDS
6. Katherine Means, Senior Director of Clinical Quality Management, DBHDS
7. Kate O'Roark, HSAG
8. Amy Osborne, HSAG

Provider Agency Onsite Interviews:

1. Exceptional People Plus, LLC, Norfolk (Region 5)
2. Pieces of Dreams, LLC, Virginia Beach (Region 5)
3. Community Alternatives, Inc., Norfolk (Region 5)
4. We Care Residential, Inc., Richmond (Region 4)
5. New Beginning, Inc., Waverly (Region 4)
6. Capriccio Elite, Galax (Region 3)
7. Highlands CSB, Abington (Region 3)
8. Dedicated Care, Annandale (Region 2)
9. Northwestern CSB, Front Royal (Region 1)
10. Valley CSB, Staunton (Region 1)

Attachment B: Documents Reviewed

V.H.1-V.H.2 (Provider Training Study)

49.1:

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 Orientation Test and Answer Sheets Effective 11.15.21
10. Narrative Version – DSP Supplemental Training Choking Risk 9.15.21.docx
11. Narrative Version – DSP Supplemental Training Recognizing Changes in Mental Status 9.15.21.docx
12. Direct Support Professional Training and Competencies Overview 3.5.21
13. DSP Supervisory Training Module 1 (Launch Story.exe).zip
14. DSP Supervisory Training Module 2 (Launch Story.exe).zip
15. DSP Supervisory Training Module 3 (Launch Story.exe).zip

49.2:

1. Virginia Administrative Code-12 VAC 30-122-180 "Orientation Testing: Professional competency Requirements; Advanced Competency Requirements
2. Cap Elite 1st FUP Attestation Signed.pdf
3. Capriccio Elite QMR ltr CL FISann.pdf
4. Dedicated Care 1stFU ltr CL FISann.pdf
5. Dedicated Care 2nd fup attestation signed.pdf
6. Dedicated Care QMR ltr signed.pdf
7. Exceptional People attestation ltr SIGNED.pdf
8. Exceptional People Plus ltrann.pdf
9. Exceptional People Plus signed attestation form.pdf
10. Highlands CSB Reg QMR ltr.pdf
11. New Beginning Attestation Statement 2022 signed.pdf
12. New Beginning ltrann.pdf
13. Northwestern CSB 1st ltr BI CL FISann.pdf
14. NWCSB 1st fup Attestation signed.pdf
15. Pieces of Dreams 1st fup signed attestation.pdf
16. Pieces of Dreams ltrann.pdf
17. Valley CSB 1st fup Attestation Ltr signed.pdf
18. Valley CSB QMR Ltr.pdf
19. We Care Initial QMR ltr.pdf
20. We Care 1st FU ltr CLann.pdf
21. We Care Residential 2nd fyp signed attestation.pdf
22. 2818-01-001 Capriccio Elite 1-14-2022 CAP.pdf
23. 2888-01-036 Capriccio Elite 1-14-2022 CAP.pdf
24. 2818-02-008 Capriccio Elite 1-14-2022 CAP.pdf
25. 2818-02-009 Capriccio Elite 1-14-2022 CAP.pdf

26. 2818-03-011 Capriccio Elite 1-14-2022 CAP.pdf
27. Capriccio R3 QSR Report 4.28.22.pdf
28. 140 Community Alternatives Inc 02-006.pdf
29. 140 Community Alternatives Inc 01-001.pdf
30. 140 Community Alternatives Inc 02-008.pdf
31. Community Alternatives VA INC R3 QSR Report 042822.pdf
32. 2417 Dedicated Care Health Services Inc 01-001 (2021).pdf
33. Dedicated Care Health Services R3 QSR Report 4.28.22.pdf
34. 2867 Exceptional People Plus LLC 02-006.pdf
35. Exceptional People R3 QSR Report 4.15.22.pdf
36. Highlands 03-011 4-1-22.pdf
37. Highlands 02-006 4-5-22.pdf
38. Highlands 02-008 4-5-22.pdf
39. Highlands 08-011 4-4-22.pdf
40. Highlands 16-002 165-16-002.pdf
41. Highlands CSB R3 QSR Report 5.2.52.pdf
42. 001-01-001 New Beginning 9-17-2021 inspection.pdf
43. CAP 001-02-006-614.docs
44. New Beginning Residential Services R3 QSR Report 4-22-22.pdf
45. 051-03-011 NWCSB Sup In-Home.pdf
46. Northwestern CSB R3 QSR Report 4.21.22.pdf
47. 2517 Pieces of Dreams LLC 01-001.pdf
48. Pieces of a Dream R3 QSR Report 4.27.22.pdf
49. 105-01-005 Valley CSB ICF.pdf
50. Valley CSB R3 QSR Report 5.6.22.pdf
51. 1118-01-001 We Care Residential Inc. CAP Partially Accepted Due 9.9.22.pdf
52. Provider training policies from each of the ten providers included in the sample – Exceptional People Plus, Pieces of Dreams, Community Alternatives, Inc., New Beginning, Inc., We Care Residential, Dedicated Care, Northwestern CSB, Valley CSB, Highlands CSB, Capriccio Elite
53. We Care Residential LLC R3 QSR Report 4.27.22.pdf
54. Provider Training Narrative 8.29.22 with OL responses (final from Eric).xlsx
55. Round 3 PQR Provider List.xlsx
56. R3 Aggregate Data by Provider FY2022.pdf
57. QSR R3 Data Analysis Report SFY2022.pdf
58. QSR R3 Narrative Aggregate Report SFY2022.pdf
59. Completed QMRs – 10.2021 to current to IR 072522.xlsx
60. QMR Scoring Template.xlsm
61. 08-01-22 CSB-and-DD-Provider-Memo QSR Cadence Change.pdf
62. DMAS Provider Data Demographic Data Summary.xlsx
63. Licensing Annual Checklist Compliance Determination Chart.docx
64. PCR Tool R4 June 22 2022 Final.docx
65. QMR Operations Manual.pdf
66. QSR Tracker (with method) (3).xlsx
67. DSP Supervisory Training Module 1 (Launch Story.exe).zip
68. DSP Supervisory Training Module 2 (Launch Story.exe).zip
69. DSP Supervisory Training Module 3 (Launch Story.exe).zip

49.3:

1. Virginia Administrative Code-12 VAC 30-122-180 "Orientation Testing: Professional competency Requirements; Advanced Competency Requirements
2. Cap Elite 1st FUP Attestation Signed.pdf

3. Capriccio Elite QMR ltr CL FISann.pdf
4. Dedicated Care 1stFU ltr CL FISann.pdf
5. Dedicated Care 2nd fup attestation signed.pdf
6. Dedicated Care QMR ltr signed.pdf
7. Exceptional People attestation ltr SIGNED.pdf
8. Exceptional People Plus ltrann.pdf
9. Exceptional People Plus signed attestation form.pdf
10. Highlands CSB Reg QMR ltr.pdf
11. New Beginning Attestation Statement 2022 signed.pdf
12. New Beginning ltrann.pdf
13. Northwestern CSB 1st ltr BI CL FISann.pdf
14. NWCSB 1st fup Attestation signed.pdf
15. Pieces of Dreams 1st fup signed attestation.pdf
16. Pieces of Dreams ltrann.pdf
17. Valley CSB 1st fup Attestation Ltr signed.pdf
18. Valley CSB QMR Ltr.pdf
19. We Care Initial QMR ltr.pdf
20. We Care 1st FU ltr CLann.pdf
21. We Care Residential 2nd fyp signed attestation.pdf
22. 2818-01-001 Capriccio Elite 1-14-2022 CAP.pdf
23. 2888-01-036 Capriccio Elite 1-14-2022 CAP.pdf
24. 2818-02-008 Capriccio Elite 1-14-2022 CAP.pdf
25. 2818-02-009 Capriccio Elite 1-14-2022 CAP.pdf
26. 2818-03-011 Capriccio Elite 1-14-2022 CAP.pdf
27. Capriccio QSR Report 4.28.22.pdf
28. 140 Community Alternatives Inc 02-006.pdf
29. 140 Community Alternatives Inc 01-001.pdf
30. 140 Community Alternatives Inc 02-008.pdf
31. Community Alternatives VA INC R3 QSR Report 042822.pdf
32. 2417 Dedicated Care Health Services Inc 01-001 (2021).pdf
33. Dedicated Care Health Services R3 QSR Report 4.28.22.pdf
34. 2867 Exceptional People Plus LLC 02-006.pdf
35. Exceptional People R3 QSR Report 4.15.22.pdf
36. Highlands 03-011 4-1-22.pdf
37. Highlands 02-006 4-5-22.pdf
38. Highlands 02-008 4-5-22.pdf
39. Highlands 08-011 4-4-22.pdf
40. Highlands 16-002 165-16-002.pdf
41. Highlands CSB R3 QSR Repoirt 5.2.52.pdf
42. 001-01-001 New Beginning 9-17-2021 inspection.pdf
43. CAP 001-02-006-614.docs
44. New Beginning Residential Services R3 QSR Report 4-22-22.pdf
45. 051-03-011 NWCSB Sup In-Home.pdf
46. Northwestern CSB R3 QSR Report 4.21.22.pdf
47. 2517 Pieces of Dreams LLC 01-001.pdf
48. Pieces of a Dream R3 QSR Report 4.27.22.pdf
49. 105-01-005 Valley CSB ICF.pdf
50. Valley CSB R3 QSR Report 5.6.22.pdf
51. 1118-01-001 We Care Residential Inc. CAP Partially Accepted Due 9.9.22.pdf
52. We Care Residential LLC R3 QSR Report 4.27.22.pdf

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55. Round 3 PQR Provider List.xlsx
56. R3 Aggregate Data by Provider FY2022.pdf
57. QSR R3 Data Analysis Report SFY2022.pdf
58. QSR R3 Narrative Aggregate Report SFY2022.pdf
59. Completed QMRs – 10.2021 to current to IR 072522.xlsx
60. QMR Scoring Template.xlsm
61. HSW Alert update training-2022-112 -0-124-Meeting Recording.mp4
62. 08-01-22 CSB-and-DD-Provider-Memo QSR Cadence Change.pdf
63. DMAS Provider Data Demographic Data Summary.xlsx
64. Licensing Annual Checklist Compliance Determination Chart.docx
65. PCR Tool R4 June 22 2022 Final.docx
66. QMR Operations Manual.pdf
67. QSR Tracker (with method) (3).xlsx
68. DSP Supervisory Training Module 1 (Launch Story.exe).zip
69. DSP Supervisory Training Module 2 (Launch Story.exe).zip
70. DSP Supervisory Training Module 3 (Launch Story.exe).zip

49.4:

1. Virginia Administrative Code-12 VAC 30-122-180 "Orientation Testing: Professional competency Requirements; Advanced Competency Requirements
2. Cap Elite 1st FUP Attestation Signed.pdf
3. Capriccio Elite QMR ltr CL FISann.pdf
4. Dedicated Care 1stFU ltr CL FISann.pdf
5. Dedicated Care 2nd fup attestation signed.pdf
6. Dedicated Care QMR ltr signed.pdf
7. Exceptional People attestation ltr SIGNED.pdf
8. Exceptional People Plus ltrann.pdf
9. Exceptional People Plus signed attestation form.pdf
10. Highlands CSB Reg QMR ltr.pdf
11. New Beginning Attestation Statement 2022 signed.pdf
12. New Beginning ltrann.pdf
13. Northwestern CSB 1st ltr BI CL FISann.pdf
14. NWCSB 1st fup Attestation signed.pdf
15. Pieces of Dreams 1st fup signed attestation.pdf
16. Pieces of Dreams ltrann.pdf
17. Valley CSB 1st fup Attestation Ltr signed.pdf
18. Valley CSB QMR Ltr.pdf
19. We Care Initial QMR ltr.pdf
20. We Care 1st FU ltr CLann.pdf
21. We Care Residential 2nd fyp signed attestation.pdf
22. 2818-01-001 Capriccio Elite 1-14-2022 CAP.pdf
23. 2888-01-036 Capriccio Elite 1-14-2022 CAP.pdf
24. 2818-02-008 Capriccio Elite 1-14-2022 CAP.pdf
25. 2818-02-009 Capriccio Elite 1-14-2022 CAP.pdf
26. 2818-03-011 Capriccio Elite 1-14-2022 CAP.pdf
27. Capriccio QSR Report 4.28.22.pdf
28. 140 Community Alternatives Inc 02-006.pdf

29. 140 Community Alternatives Inc 01-001.pdf
30. 140 Community Alternatives Inc 02-008.pdf
31. Community Alternatives VA INC R3 QSR Report 042822.pdf
32. 2417 Dedicated Care Health Services Inc 01-001 (2021).pdf
33. Dedicated Care Health Services R3 QSR Report 4.28.22.pdf
34. 2867 Exceptional People Plus LLC 02-006.pdf
35. Exceptional People R3 QSR Report 4.15.22.pdf
36. Highlands 03-011 4-1-22.pdf
37. Highlands 02-006 4-5-22.pdf
38. Highlands 02-008 4-5-22.pdf
39. Highlands 08-011 4-4-22.pdf
40. Highlands 16-002 165-16-002.pdf
41. Highlands CSB R3 QSR Report 5.2.52.pdf
42. 001-01-001 New Beginning 9-17-2021 inspection.pdf
43. CAP 001-02-006-614.docs
44. New Beginning Residential Services R3 QSR Report 4-22-22.pdf
45. 051-03-011 NWCSB Sup In-Home.pdf
46. Northwestern CSB R3 QSR Report 4.21.22.pdf
47. 2517 Pieces of Dreams LLC 01-001.pdf
48. Pieces of a Dream R3 QSR Report 4.27.22.pdf
49. 105-01-005 Valley CSB ICF.pdf
50. Valley CSB R3 QSR Report 5.6.22.pdf
51. 1118-01-001 We Care Residential Inc. CAP Partially Accepted Due 9.9.22.pdf
52. We Care Residential LLC R3 QSR Report 4.27.22.pdf
53. Provider Training Narrative 8.29.22 with OL responses (final from Eric).xlsx
54. Round 3 PQR Provider List.xlsx
55. R3 Aggregate Data by Provider FY2022.pdf
56. QSR R3 Data Analysis Report SFY2022.pdf
57. QSR R3 Narrative Aggregate Report SFY2022.pdf
58. Completed QMRs – 10.2021 to current to IR 072522.xlsx
59. QMR Scoring Template.xlsm
60. DQMP Recommendations Progress as of 8.26.22 (1).pdf
61. 08-01-22 CSB-and-DD-Provider-Memo QSR Cadence Change.pdf
62. DMAS Provider Data Demographic Data Summary.xlsx
63. PDS State of the State slides 7-21-22 FINAL PDF.pdf
64. Provider Data Summary Report May 2022 PDF final v.7.21.22.pdf
65. Licensing Annual Checklist Compliance Determination Chart.docx
66. DD Provider Data Summary VER 002 (9.8.22).docx
67. PCR Tool R4 June 22 2022 Final.docx
68. QMR Operations Manual.pdf
69. QSR Tracker (with method) (3).xlsx
70. DSP Supervisory Training Module 1 (Launch Story.exe).zip
71. DSP Supervisory Training Module 2 (Launch Story.exe).zip
72. DSP Supervisory Training Module 3 (Launch Story.exe).zip

49.5:

1. Behavioral Services Updates Since 10.2021docs.pdf
2. Anaphylaxis H&S Alert – June 2022 (1).pdf
3. Aspiration Pneumonia H&S Alert – October 2021.odf
4. BSPARI feedback session email 5.17.2022.JPG
5. BSPARI feedback session email 8.15.2022.JPG

6. BSPARI Scoring Instructions Guide & Feedback Process.pdf
7. BSPARI Trends 8.2022.pdf
8. BSPARI.xlsm
9. October 2021 Newsletter.pdf
10. December 2021 Newsletter.pdf
11. February 2022 Newsletter (1).pdf
12. March 2022 Newsletter (2).pdf
13. April 2022 Newsletter (2).pdf
14. June 2022 Newsletter (1).pdf
15. July 2022 Newsletter (1).pdf
16. August 2022 Newsletter (1).pdf
17. IDD Health & Safety Alert – Aug 2022 (1).pdf
18. Leading fatalities in DD H&S Alert March 2022 (3).pdf
19. My Care Passport & Advocacy Tips H&S Alert – Feb 2022 (1).pdf
20. OHI Training Offerings COVLC.pdf
21. Polypharmacy H&S Alert – Nov 21.pdf
22. Practice Guidelines for BSPs.pdf
23. Quality Review in Behavior Support Planning 1.20.2022 for PBSFs.pdf
24. Quality Review in Behavior Support Planning 1.6.2022.pdf
25. Skin Integrity Announcement flyer 07.12.22 (1).pdf
26. SN PDN Training Flyer (3).pdf
27. Winter 2022 Training Announcement (1).pdf
28. Additional Winter 2022 trainings (1).pdf
29. OIH Spring 2022 Training Schedule (1).pdf
30. Summer 2022 OIH-HSN Training Schedule (3).pdf
31. Vital Signs H&S Alert – Nov 21.pdf
32. Wheelchair Safety & Maintenance H&S Alert – Apr 2022 (2).pdf
33. Provider Training Narrative 8.29.22 with OL responses (final from Eric).xlsx

49.6:

1. Virginia Administrative Code-12 VAC 30-122-180 "Orientation Testing: Professional competency Requirements; Advanced Competency Requirements
2. Provider Training Narrative 8.29.22 with OL responses (final from Eric).xlsx
3. CONTRACT 10041 – Final Executed (Includes BAA).pdf
4. Contract 10041 Mod 2 OY Renewal 1 Fully Executed.pdf
5. Contract 10041 Modification 1 Executed 12.20.18.pdf
6. DMAS – Contract 10041 Mod 3 OY Renewal 2 fully executed.pdf
7. DOJ Modivcare FFS NEMT SLA Amounts Transportation Study for SFY 2022.docx
8. RFT 2018-01 NEMT FINAL 092017 (002).pdf

49.7:

1. Provider Training Narrative 8.29.22 with OL responses (final from Eric).xlsx
2. October 2021 Nursing Meeting Agenda.pdf
3. November 2021 Nursing Meeting Agenda.pdf
4. December 2021 Nursing Meeting Agenda.pdf
5. January 2022 Nursing Meeting Agenda.pdf
6. February 2022 Nursing Meeting Agenda.pdf
7. March 2022 Nursing Meeting Agenda.pdf
8. April 2022 Nursing Meeting Agenda.pdf
9. May 2022 Nursing Meeting Agenda.pdf
10. June 2022 Nursing Meeting Agenda.pdf

11. July 2022 Nursing Meeting Agenda.pdf
12. August 2022 Nursing Meeting Agenda.pdf
13. Nursing Conference Emergency Evacuation Devices presentation for Virginia Nurses Annual Mtg.pdf
14. Nursing Conference Intro Nursing Services Under the DD Waivers in VA 2022.pdf
15. Nursing Conference Intro RM.QI.pdf
16. Nursing Conference Nsg Conf AGENDA 101322.pdf
17. Nursing Conference Quillo Presedntation.pdf
18. Save the Date 3rd Statewide Nursing Meeting (1).pdf

49.8:

1. Virginia Administrative Code-12 VAC 35-105-30 "Licenses"
2. Virginia Administrative Code-12VAC35-105-440 "Orientation of New Employees, Contractors, Volunteers, and Students"
3. Capriccio QSR Report 4.28.22.pdf
4. Community Alternatives VA INC R3 QSR Report 042822.pdf
5. Dedicated Care Health Services R3 QSR Report 4.28.22.pdf
6. Exceptional People R3 QSR Report 4.15.22.pdf
7. Highlands CSB R3 QSR Report 5.2.52.pdf
8. New Beginning Residential Services R3 QSR Report 4-22-22.pdf
9. Northwestern CSB R3 QSR Report 4.21.22.pdf
10. Pieces of a Dream R3 QSR Report 4.27.22.pdf
11. Valley CSB R3 QSR Report 5.6.22.pdf
12. We Care Residential LLC R3 QSR Report 4.27.22.pdf
13. 2818-01-001 Capriccio Elite 1-14-2022 CAP.pdf
14. 2888-01-036 Capriccio Elite 1-14-2022 CAP.pdf
15. 2818-02-008 Capriccio Elite 1-14-2022 CAP.pdf
16. 2818-02-009 Capriccio Elite 1-14-2022 CAP.pdf
17. 2818-03-011 Capriccio Elite 1-14-2022 CAP.pdf
18. 140 Community Alternatives Inc 02-006.pdf
19. 140 Community Alternatives Inc 01-001.pdf
20. 140 Community Alternatives Inc 02-008.pdf
21. 2417 Dedicated Care Health Services Inc 01-001 (2021).pdf
22. 2867 Exceptional People Plus LLC 02-006.pdf
23. Highlands 03-011 4-1-22.pdf
24. Highlands 02-006 4-5-22.pdf
25. Highlands 02-008 4-5-22.pdf
26. Highlands 08-011 4-4-22.pdf
27. Highlands 16-002 165-16-002.pdf
28. 001-01-001 New Beginning 9-17-2021 inspection.pdf
29. CAP 001-02-006-614.docs
30. 051-03-011 NWCSB Sup In-Home.pdf
31. 2517 Pieces of Dreams LLC 01-001.pdf
32. 105-01-005 Valley CSB ICF.pdf
33. 1118-01-001 We Care Residential Inc. CAP Partially Accepted Due 9.9.22.pdf
34. Provider training policies from each of the ten providers included in the sample – Exceptional People Plus, Pieces of Dreams, Community Alternatives, Inc., New Beginning, Inc., We Care Residential, Dedicated Care, Northwestern CSB, Valley CSB, Highlands CSB, Capriccio Elite
35. Provider Training Narrative 8.29.22 with OL responses (final from Eric).xlsx
36. Licensing Data for 49.8, 49.9, 49.10, 49.12 Provider Training Narrative Attachment 1 – Compliance Calendar Year 2022 (final).xlsx

37. Licensing Annual Checklist Compliance Determination Chart.docx
38. PCR Tool R4 June 22 2022 Final.docx
39. QMR Operations Manual.pdf
40. QSR Tracker (with method) (3).xlsx

49.9:

1. Virginia Administrative Code-12VAC35-105-665 "ISP Requirements"
2. Capriccio QSR Report 4.28.22.pdf
3. Community Alternatives VA INC R3 QSR Report 042822.pdf
4. Dedicated Care Health Services R3 QSR Report 4.28.22.pdf
5. Exceptional People R3 QSR Report 4.15.22.pdf
6. Highlands CSB R3 QSR Report 5.2.52.pdf
7. New Beginning Residential Services R3 QSR Report 4-22-22.pdf
8. Northwestern CSB R3 QSR Report 4.21.22.pdf
9. Pieces of a Dream R3 QSR Report 4.27.22.pdf
10. Valley CSB R3 QSR Report 5.6.22.pdf
11. We Care Residential LLC R3 QSR Report 4.27.22.pdf
12. 2818-01-001 Capriccio Elite 1-14-2022 CAP.pdf
13. 2888-01-036 Capriccio Elite 1-14-2022 CAP.pdf
14. 2818-02-008 Capriccio Elite 1-14-2022 CAP.pdf
15. 2818-02-009 Capriccio Elite 1-14-2022 CAP.pdf
16. 2818-03-011 Capriccio Elite 1-14-2022 CAP.pdf
17. 140 Community Alternatives Inc 02-006.pdf
18. 140 Community Alternatives Inc 01-001.pdf
19. 140 Community Alternatives Inc 02-008.pdf
20. 2417 Dedicated Care Health Services Inc 01-001 (2021).pdf
21. 2867 Exceptional People Plus LLC 02-006.pdf
22. Highlands 03-011 4-1-22.pdf
23. Highlands 02-006 4-5-22.pdf
24. Highlands 02-008 4-5-22.pdf
25. Highlands 08-011 4-4-22.pdf
26. Highlands 16-002 165-16-002.pdf
27. 001-01-001 New Beginning 9-17-2021 inspection.pdf
28. CAP 001-02-006-614.docs
29. 051-03-011 NWCSB Sup In-Home.pdf
30. 2517 Pieces of Dreams LLC 01-001.pdf
31. Pieces of a Dream R3 QSR Report 4.27.22.pdf
32. 105-01-005 Valley CSB ICF.pdf
33. 1118-01-001 We Care Residential Inc. CAP Partially Accepted Due 9.9.22.pdf
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36. Licensing Data for 49.8, 49.9, 49.10, 49.12 Provider Training Narrative Attachment 1 – Compliance Calendar Year 2022 (final).xlsx
37. Licensing Annual Checklist Compliance Determination Chart.docx
38. PCR Tool R4 June 22 2022 Final.docx
39. QMR Operations Manual.pdf
40. QSR Tracker (with method) (3).xlsx

49.10:

1. Virginia Administrative Code-12VAC30-122-120.A.20 "Provider Requirements"
2. Virginia Administrative Code-18VAC90-21-30 & 40 "Content of Medication Administration Training"
3. Virginia Administrative Code-12VAC35-105-770 "Medication Management"
4. Virginia Administrative Code-12VAC35-105-790 "Medication Administration and Storage or Pharmacy Operation"
5. Virginia Administrative Code-12VAC35-105-450 "Employee Training and Development"
6. 2818-01-001 Capriccio Elite 1-14-2022 CAP.pdf
7. 2888-01-036 Capriccio Elite 1-14-2022 CAP.pdf
8. 2818-02-008 Capriccio Elite 1-14-2022 CAP.pdf
9. 2818-02-009 Capriccio Elite 1-14-2022 CAP.pdf
10. 2818-03-011 Capriccio Elite 1-14-2022 CAP.pdf
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12. 140 Community Alternatives Inc 01-001.pdf
13. 140 Community Alternatives Inc 02-008.pdf
14. 2417 Dedicated Care Health Services Inc 01-001 (2021).pdf
15. 2867 Exceptional People Plus LLC 02-006.pdf
16. Highlands 03-011 4-1-22.pdf
17. Highlands 02-006 4-5-22.pdf
18. Highlands 02-008 4-5-22.pdf
19. Highlands 08-011 4-4-22.pdf
20. Highlands 16-002 165-16-002.pdf
21. 001-01-001 New Beginning 9-17-2021 inspection.pdf
22. CAP 001-02-006-614.docs
23. 051-03-011 NWCSB Sup In-Home.pdf
24. 2517 Pieces of Dreams LLC 01-001.pdf
25. 105-01-005 Valley CSB ICF.pdf
26. 1118-01-001 We Care Residential Inc. CAP Partially Accepted Due 9.9.22.pdf
27. Provider training policies from each of the ten providers included in the sample – Exceptional People Plus, Pieces of Dreams, Community Alternatives, Inc., New Beginning, Inc., We Care Residential, Dedicated Care, Northwestern CSB, Valley CSB, Highlands CSB, Capriccio Elite
28. 12VAC35-105-450.pdf
29. 18VAC90-21-40. Post-Course Examination (2).pdf
30. BON Approved Med Aid Curriculums (1).pdf
31. Provider Training Narrative 8.29.22 with OL responses (final from Eric).xlsx
32. Licensing Data for 49.8, 49.9, 49.10, 49.12 Provider Training Narrative Attachment 1 – Compliance Calendar Year 2022 (final).xlsx
33. Licensing Annual Checklist Compliance Determination Chart.docx

49.11:

1. Virginia Administrative Code-12VAC30-122-120.A.20 "Provider Requirements"
2. Virginia Administrative Code-12VAC35-105-810 "Behavior Treatment Plan"
3. Virginia Administrative Code-12VAC35-115-110 "Use of Seclusion, Restraint, and Time Out"
4. Capriccio QSR Report 4.28.22.pdf
5. Community Alternatives VA INC R3 QSR Report 042822.pdf
6. Dedicated Care Health Services R3 QSR Report 4.28.22.pdf
7. Exceptional People R3 QSR Report 4.15.22.pdf
8. Highlands CSB R3 QSR Report 5.2.52.pdf
9. New Beginning Residential Services R3 QSR Report 4-22-22.pdf
10. Northwestern CSB R3 QSR Report 4.21.22.pdf

11. Pieces of a Dream R3 QSR Report 4.27.22.pdf
12. Valley CSB R3 QSR Report 5.6.22.pdf
13. We Care Residential LLC R3 QSR Report 4.27.22.pdf
14. 2818-01-001 Capriccio Elite 1-14-2022 CAP.pdf
15. 2888-01-036 Capriccio Elite 1-14-2022 CAP.pdf
16. 2818-02-008 Capriccio Elite 1-14-2022 CAP.pdf
17. 2818-02-009 Capriccio Elite 1-14-2022 CAP.pdf
18. 2818-03-011 Capriccio Elite 1-14-2022 CAP.pdf
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20. 140 Community Alternatives Inc 01-001.pdf
21. 140 Community Alternatives Inc 02-008.pdf
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24. Highlands 03-011 4-1-22.pdf
25. Highlands 02-006 4-5-22.pdf
26. Highlands 02-008 4-5-22.pdf
27. Highlands 08-011 4-4-22.pdf
28. Highlands 16-002 165-16-002.pdf
29. 001-01-001 New Beginning 9-17-2021 inspection.pdf
30. CAP 001-02-006-614.docs
31. 051-03-011 NWCSB Sup In-Home.pdf
32. 2517 Pieces of Dreams LLC 01-001.pdf
33. 105-01-005 Valley CSB ICF.pdf
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36. Provider Training Narrative 8.29.22 with OL responses (final from Eric).xlsx
37. Licensing Annual Checklist Compliance Determination Chart.docx
38. PCR Tool R4 June 22, 2022 Final.docx
39. QMR Operations Manual.pdf
40. QSR Tracker (with method) (3).xlsx

49.12:

1. Virginia Administrative Code-12 VAC 35-105-30 "Licenses"
2. Virginia Administrative Code-12VAC35-105-450 "Employee Training and Development"
3. Virginia Administrative Code-12VAC35-105-50, 100, 110, 150 "Rules and Regulations for Licensing Providers by the Department of Behavioral Health and Developmental Services"
4. Provider Training Narrative 8.29.22 with OL responses (final from Eric).xlsx
5. Annual inspections for DD services since 10 2021.xlsx
6. Chris inspection list follow up (08-04-22) (2) (1).xlsx
7. Licensing Data for 49.8, 49.9, 49.10, 49.12 Provider Training Narrative Attachment 1 – Compliance Calendar Year 2022 (final).xlsx
8. Licensing Inspection Additional Info Needed (08-03-2022).xlsx
9. DQMP Recommendations Progress as of 8.26.22 (1).pdf
10. Licensing Annual Checklist Compliance Determination Chart.docx
11. DD Provider Data Summary VER 002 (9.8.22).docx

49.13:

1. Provider Training Narrative 8.29.22 with OL responses (final from Eric).xlsx
2. Process for PRT and QMR mtgs.pdf
3. Statewide PRT SC power point 10-2021 (final for online).pdf
4. Statewide PRT SC power point 1-2022 (final for online) SLIDES.pdf
5. Statewide PRT SC power point 4-2022 final.pdf
6. Statewide PRT SC PP 7.27.22 final.pdf

50.1:

1. Virginia Administrative Code-12 VAC 30-122-180 "Orientation Testing: Professional competency Requirements; Advanced Competency Requirements
2. Provider Training Narrative 8.29.22 with OL responses (final from Eric).xlsx
3. DSP Supervisory Training Module 1 (Launch Story.exe).zip
4. DSP Supervisory Training Module 2 (Launch Story.exe).zip
5. DSP Supervisory Training Module 3 (Launch Story.exe).zip

50.2:

1. Virginia Administrative Code-12 VAC 30-122-180 "Orientation Testing: Professional competency Requirements; Advanced Competency Requirements
2. Provider Training Narrative 8.29.22 with OL responses (final from Eric).xlsx
3. DBHDS DSP Supervisor Orientation Training 11.1.21 to 4.30.22.xlsx
4. DSP Supervisory Training Module 1 (Launch Story.exe).zip
5. DSP Supervisory Training Module 2 (Launch Story.exe).zip
6. DSP Supervisory Training Module 3 (Launch Story.exe).zip

50.3:

1. Provider Training Narrative 8.29.22 with OL responses (final from Eric).xlsx
2. DSP Supervisory Training Module 1 (Launch Story.exe).zip
3. DSP Supervisory Training Module 2 (Launch Story.exe).zip
4. DSP Supervisory Training Module 3 (Launch Story.exe).zip
5. October 2021 Nursing Meeting Agenda.pdf
6. November 2021 Nursing Meeting Agenda.pdf
7. December 2021 Nursing Meeting Agenda.pdf
8. January 2022 Nursing Meeting Agenda.pdf
9. February 2022 Nursing Meeting Agenda.pdf
10. March 2022 Nursing Meeting Agenda.pdf
11. April 2022 Nursing Meeting Agenda.pdf
12. May 2022 Nursing Meeting Agenda.pdf
13. June 2022 Nursing Meeting Agenda.pdf
14. July 2022 Nursing Meeting Agenda.pdf
15. August 2022 Nursing Meeting Agenda.pdf
16. Statewide PRT SC power point 10-2021 (final for online).pdf
17. Statewide PRT SC power point 1-2022 (final for online) SLIDES.pdf
18. Statewide PRT SC power point 4-2022 final.pdf
19. Statewide PRT SC PP 7.27.22 final.pdf

APPENDIX H

Quality and Risk Management, Regional Quality Councils, Quality Improvement Programs, Quality Service Reviews, and Public Reporting

by

Rebecca Wright, MSW, LICSW

Consortium on Innovative Practices

Report to the Independent Reviewer
United States v. Commonwealth of Virginia

Quality and Risk Management System

By

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November 15, 2022

Quality and Risk Management System 21st 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 21st 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, 5.a and 5.b: 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 Reports with regard to these provisions, (i.e., his 17th and 19th Reports to the Court, dated December 15, 2020 and December 13, 2021, respectively), found the Commonwealth had not achieved compliance for any of these provisions overall.
For this 21st 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 system of documents, a library (i.e., the Library Website) 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.

This study methodology was intended to determine the Commonwealth's status regarding whether it has Met, or Not Mt, the Compliance Indicators associated with these same Provisions.

The methodology will include a review of the documents that Virginia maintains to demonstrate that it has properly implemented and fulfilled the Agreement's requirements, interviews with state officials, subject matter experts, and stakeholders, verification that Virginia's relevant Process Document and Attestation are complete, data analysis and an Individual Services Review (ISR) of individuals with complex medical needs.

The review will also include confirmation that the Process Document(s) for each Indicator that depends on reliable and valid data include:

- a list of the threats to data integrity previously identified by DBHDS's assessments (with document titles and dates);
- the actions taken and completion dates that resolved these problem(s);
- the verification process that Virginia completed (with date) that confirmed that the data reported is reliable and valid; and
- the date when the Commonwealth's Attestation that the Process Document was properly completed and that the data reported are reliable and valid.

In addition, where the Parties have agreed to Curative Actions relevant to any of these Compliance Indicators as of the date of this proposal, the study will also review the current status of implementation.

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 2022. 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.

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 was severely hampered by the lack of valid and reliable data across much of the system. These previous studies 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 17th Period review, the study documented that the Office of Data Quality and Visualization [which DBHDS now calls the Office of Epidemiology and Health Analytic (EHA)] 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 the19th 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 in 2021 (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 that 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 36.6, data sources cannot be used for compliance reporting until they have been found to be valid and reliable.

For the19th Period Review, the Office of DQV acknowledged that the recommendations from the original version of the *DBHDS Data Quality Monitoring Plan (DQMP)* 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 2021 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, the 2021 study could not complete an independent verification of the assertions or processes contained in the documents.

Since that time, DBHDS and DOJ also agreed upon a Curative Action for Provision V.D.2.a.-d. (i.e., Compliance Indicator 36.1) to address validity and reliability of data sets DBHDS uses to report compliance. On 1/21/22 they jointly filed with the Court this agreed-upon curative action that noted that "the Independent Reviewer had identified concerns with the Commonwealth's data reliability and validity specific to particular source systems and that, further, many of the Data Source Systems were outdated compared to the advancements in IT and have planned investments for replacements over the next several years. All parties, the IR, DOJ, and the Commonwealth recognize that bringing source systems in compliance is a multi-year and multimillion dollar process and poses a challenge in exiting the Settlement Agreement in a timely manner."

"DQV will continue to review data sources and update the quality management plan annually as required. DQV will also continue to make recommendations around actionable items with the systems to increase their quality. Additionally, every 3-5 years DQV will do a deep dive into each source system to test and follow the data, from the entering of data into the source system to the reporting of the data from the data set(s). DQV will review and identify concerns related to source systems and will identify threats to the data reliability and validity. DQV provides technical assistance to the SME in collaboration with IT (See "Actionable Steps to Improve Data Validity and Reliability for Target Source Systems," April 23, 2021) to correct threats to data. This improvement will be reviewed with DQV. Assertion of data reliability and validity will be completed by the Chief Data Officer (CDO) once threats have been alleviated."

This was consistent with processes DBHDS described at the time of the 19th Period review. At that time, DBHDS submitted documentation that detailed what appeared to be a well-thought-out process for reviewing each primary data source system and for the identification of actionable remedial recommendations DBHDS could take. As of the time of this 21st Period review, the process thus far has seen completion of four such reviews (i.e., for AVATAR, the Children in Nursing Facilities Spreadsheet, the Comprehensive Employment Spreadsheet and WaMS). Of note for the other data source systems that the Office of DQV previously reviewed, however, there remained prior findings of deficiencies that the data set attestation processes needed to address. In addition, a number of data source systems were pending replacement.

The agreed-upon curative action also asserted that "the data that comes from the existing system can still be used to create valid and reliable data sets. The data source system is not what drives the quality and risk management programs, it is the data that comes from these systems and how it is used to make improvements. The Commonwealth uses Data Sets to analyze, report, and make decisions. The use of Data Sets is based on the basic principle: 'What is not defined cannot be measured. What is not measured cannot be improved."

In the curative action, the Commonwealth stated that DBHDS staff had "put together a process that identified all of the data sets that get reported to the Quality Improvement Committee or a subcommittee. If it is part of a report that we use to assert compliance, we are cataloging all of the relevant data sets in a spreadsheet so that we can document the process for collecting each data set, incorporating (a) tool developed by DQV. This data measurement tool (i.e., Process Document) clearly identifies numerators, denominator, methodology, baseline and definitions of different items that we have been collecting." The curative action provided the following details of the Data Set Attestation procedures:

1. Assistant Commissioner/Designee will collect information regarding all data sets reported to the QIC and used to demonstrate compliance. Date of completion: December 31, 2021.
2. Subject Matter Experts (SME) responsible for data productions will conduct the following actions to ensure data validity:

a. Document the process for collecting the data including the data measurement tool (called the "Process Document").
b. SME will also identify and document data verification process (for example, a look-behind process, comparison against billing data, external expert consultants, end-user feedback, etc.).
c. Have the process reviewed and approved by the data project manager.
    i. Review and document for any element of subjectivity
    ii. Ensure all business rules are clearly documented
    iii. Process is easily understandable by non-data staff
d. Date of completion: January 31, 2022.

3. Subject Matter Experts (SME) responsible for data production will conduct the following actions to ensure data reliability:
    e. Submit process and data to a data analyst to ensure data reliability following the documented process.
    f. Any concerns identified in reliability are shared with the SME and when appropriate IT to resolve the issues.
4. Once all issues are resolved, and data reliability and validity are verified, the Chief Data Officer (CDO) will assert data set quality by signing off on a Data Set Attestation Form for the data set. Date of completion: March 1, 2022 (for all compliance indicators measured in the Independent Reviewer's 20th Report) and June 1, 2022 (for all compliance indicators measured in the Independent Reviewer's 21st Report).

Accompanying the curative action, DBHDS provided a document entitled *Attachment C DOJ SA Process Document - DQV DQ Verification Process*. DBHDS stated the purpose of its Process Document is to document the process that will establish traceability of data quality monitoring activities around data quality recommendations. Further, the Commonwealth's Process Document identified the input or trigger for the data quality attestation procedures as recommendations generated by the Office of DQV around identified areas of improvement within data source systems and data reporting. In other words, the Commonwealth committed to a clear expectation that a final data set attestation would occur once appropriate DBHDS staff had addressed and resolved the reliability and validity deficiencies identified by the Office of DQV and described in the Process Document. During the 20th review period, DBHDS also provided a "Data Governance" Process Document to further describe the methodology for the implementation of the data set attestation process. In particular, for purposes of this discussion, this document also indicated that the input or trigger for the undertaking of a data set attestation would include "DQV Data Source System Assessments, New Data Report required for DOJ Settlement Agreement, New Data Report required for reporting purposes, New Data need identified by QIC or subcommittees."

Accordingly, the Independent Reviewer instructed consultants completing studies for this review period to review the relevant Process Document(s) and Data Set Attestation Form(s) for each CI in the relevant studies, to review previous findings by the Office of DQV to determine what, if any, reliability and validity deficiencies (i.e., related to a) the data collection methodology and/or b) the data source system), and to review and analyze the documented facts related to the extent to which the Process Document appears to have sufficiently addressed all previously identified deficiencies/threats related to data reliability and validity.

Based on review of the documents DBHDS provided, this study could not consistently confirm that DBHDS staff completed the required Process Document and/or the applicable Data Set Attestation Forms for PMI, or other provisions reviewed for this 21st Period that require a review of reliable and valid data, in a manner that demonstrated the DBHDS staff have identified, isolated and addressed applicable reliability and validity deficiencies in the data source systems. In many instances, the Commonwealth was

not able to provide a completed Process Document which would have the required information that provides the factual basis for the Commonwealth to complete and sign a data set attestations. The Curative Action did not describe the data set attestation as a stand-alone document, because it does not include sufficient information to demonstrate, or to review and verify, how the specific pertinent data source system reliability and validity deficiencies were isolated, addressed, and resolved.

Overall, because CI 36.1 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 will 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 21st 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 which it 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 still failed to put a sufficient focus on systemic remediation. The QRT issued a timely End of Year report.

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 21st Period review, DBHDS continued to collect data from all of the designated sources, but had not analyzed data from at least two (CHRIS-SIR/CONNECT and NCI) during this past year. 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 nine of the previously studied source systems, but did not assert that any of the source systems produced valid and reliable data.

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, including with regard to the inclusion of measurable outcomes. 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 continued to be compromised by 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 had issued a Provider Data Summary and Quality Management Plan that addressed the relevant CIs. Many of the documents posted to the Library were out of date. In addition, there continued to be concerns due to a lack of valid and reliable data.

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. DBHDS also provided an operational protocol to show how DBHDS staff would determine whether updates and/or revisions to this guidance were necessary. DBHDS submitted current documentation to show the Training Center had in place the required procedures, protocols and/or processes to implement a quality improvement program. However, 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. 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, and the Parties had agreed on a Curative Action, with the Court on 11/9/21 to specify compliance criteria. While this process was underway, it had not yet been fully implemented. In addition, DBHDS did not

provide documentation to show that the Office of EHA completed sufficient needed assistance with analysis of all of the provider reporting of key 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. In addition, based on the findings for CI 36.1, for many of the applicable data sets, DBHDS had not yet determined they 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. For this review, the QSR PQR Tool included seven questions related to the provider's quality improvement program. Each question was accompanied by specific Evaluation Criteria Reviewer Notes that provided additional guidance, but these sometimes appeared to conflict. Combined with concerns for the adequacy of inter-rater reliability identified at the time of the 20th Period review, the procedures to evaluate providers' quality improvement programs were not yet sufficient. In addition, DBHDS had not completed an evaluation of the QSR source system to establish that the data were valid and reliable.

The questions, evaluation criteria and additional guidelines overall did not provide a clear procedure for addressing each of the specific criteria defined in the CI as necessary to the assessment and determination of the adequacy of providers' quality improvement programs

Conclusion:
The tables below illustrate the current compliance status for each Compliance Indicator. Status indicators in bold indicate a change from the previous compliance finding.
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
32.1: 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
32.2: 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
32.3: 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.	**Met**
32.4: 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
32.5: DBHDS offers written guidance to providers (including residential, day/employment, and case management) on how to proactively identify and address	Met

V.C.4 Compliance Indicators	Status
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.	
32.6: 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
32.7: 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
32.8: 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
32.9: 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
35.1: The Commonwealth implements the Quality Improvement Plan approved by CMS in the operation of its HCBS Waivers.	Not Met
35.2: 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
35.3 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	**Met***

V.D.1. Compliance Indicators	Status
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).	
35.4: The performance measures are found in the published DD HCBS waivers and found at cms.gov and are posted on the DBHDS website.	Met
35.5: 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
35.6: 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
35.7: 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
35.8: 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	Met*

V.D.2 Compliance Indicators	Status
36.1: 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
36.2: 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	Met*

V.D.2 Compliance Indicators	Status
information.	
36.3 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
36.4: 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).	**Met***
36.5: 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
36.6: 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.	**Met***
36.7: DBHDS demonstrates annually at least 3 ways in which it has utilized data collection and analysis to enhance outreach, education, or training.	Met*
36.8: 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
37.1: 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,	Met*

V.D.3 Compliance Indicators	Status
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	
37.2: 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.	**Met***
37.3 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
37.4: 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
37.5: 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	**Met***
37.6: 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.	**Met***
37.7: 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
37.8: The Quality Management Annual Report will describe the accomplishments and barriers for each KPA.	Met

V.D.3 Compliance Indicators	Status
37.9: 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 (ECM); National Core Indicators - (i.e., Health, Welfare and Rights); Individual and Provider Quality Service Reviews (QSRs); QMRs	Met*
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	Met*

V.D.3 Compliance Indicators	Status
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	
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*
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
38.1: 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
39.1: 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	Met

V.D.5 Compliance Indicators	Status
receiving services, and families, and may include other relevant stakeholders."	
39.2: 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
39.3 Each DBHDS Region has convened a RQC that serves as a subcommittee to the QIC as described in indicator V.B.4.	Met
39.4: 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).	**Met***
39.5: 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.	**Met***
V.D.5.b Compliance Indicators	**Status**
40.1: 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
40.2: 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*
40.3: 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
40.4: 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
40.5: For each quality improvement initiative recommended by the RQC, at least one measurable outcome will be proposed by the RQC.	**Met***
40.6: 100% of recommendations agreed upon by the RQCs are presented to the DBHDS QIC.	Met
40.7: 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.	**Met**

V.D.5 Compliance Indicators	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.	

V.D.6 Compliance Indicators	Status
41.1: 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.	**Met***
41.2: 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.	**Met***
41.3: 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	**Met***
35.4: 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	**Met***

V.D.6 Compliance Indicators	Status
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	
41.5: 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. Integrated Day Services Report k. DBHDS Annual Report l. National Core Indicators Annual Report and Bi-Annual National Report.	Not Met

V.E.1 Compliance Indicators	Status
42.1: 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.	Met
42.2: 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
42.3 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
42.4: 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
42.5: 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	**Met**

V.E.1 Compliance Indicators	Status
analysis; d. Establish facility-wide quality improvement initiatives; and e. Monitor implementation and effectiveness of quality improvement initiatives.	

V.E.2 Compliance Indicators	Status
43.1: 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
43.2: 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
43.3: 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
44.1: 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
44.2: 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.	**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
32.1: 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 and 19th Period reviews, 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 21st Period review, DBHDS provided the following list of current offerings to address these three topics: Proactively identifying and addressing risks of harm: • Guidance for Risk Management (August 2020) • Individual and Systemic Risk – How to Report and Respond to Incidents (April 2022) • Risk Management & Quality Improvement Strategies Training by the Center for Developmental Disabilities Evaluation & Research – Recorded Webinar (December 2020) • Risk Awareness Tool - Understanding the Risk Awareness Tool and Use with the WaMS v3.3 ISP • Risk Awareness Tool – FAQ • Health & Safety Alerts, Courses and Educational Resources offered on the Office of Integrated Health (OIH) webpage. Examples included: o Leading Causes of Fatalities – March 2022 o Vital Signs – November 2021 o Aspiration Pneumonia – October 2021 o Health Risks (Aspiration Pneumonia; Constipation and Bowel Obstruction; Dehydration; Falls; Pressure Injury Training; Seizures; Sepsis; Urinary Tract Infection (UTI) • Assuring Health and Safety for Individuals with Developmental Disabilities	19th Met **21st Met**

Compliance Indicator	Facts	Analysis	Conclusion
		with a Comprehensive Risk Management Plan • Sample Provider Systemic Risk Assessment (February 2022) • Sample Risk Management Plan (June 2021) • Risk Management Quality Improvement Tips and Tools (June 2021) Conducting Root Cause Analysis: • Flow Chart – Incident Reviews (April 2022) • Sample Root Cause Analysis Policy (February 2022) • QI-RM-RCA Webinar (December 2021) • Regulatory Compliance with Root Cause Analysis Regulations Training (December 2021) • 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 (webinar recording) • Root Cause Analysis in Developmental Disabilities – CDDER on-line course Developing and monitoring corrective actions: • 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) • Risk Management Quality Improvement Tips and Tools (June 2021)	
32.2: Training(s) or educational resources in each topical area identified in Indicator 1	For this review, training and topical resource reference materials continued to be	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	19 h Met **21st Met**

Compliance Indicator	Facts	Analysis	Conclusion
will be made available to providers through the DBHDS website, or other on-line systems.	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 Provider Listserv.	subscribers to the DBHDS Listserv.	
32.3: 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	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. In addition to an updated *Internal Protocol*	At the time of previous 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. Also, at the time of the previous 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	19th Not Met **21st Met**

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plan.	*for assessing Compliance with 12VAC35-105-520 and 12VAC35-105-160.E*, dated February 2022, in August 2022, OL had created *New Hire Orientation Training for* 160, 520 and 620 with expanded examples of how Licensing Specialists should assess compliance in various scenarios. DBHDS also provided a *2022 Office of Licensing Look Behind Process for DD Providers Annual Inspections DV*, dated 2/17/22, that included a protocol for the Quality Improvement Review Specialist to monitor the submissions of Attestations with CAPs for providers cited for 160.E and 520, to report the status to the appropriate Licensing Specialist and to maintain a tracking spreadsheet.	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 where quested by the Office of Licensing, including when requested during onsite and remote inspections. The primary deficiency at the time of previous reviews was that OL did not provide evidence to show that they tracked evidence that noncompliant providers implemented corrective action plans pursuant to the requirements of this CI. For this 21st Period review, these procedures remained in effect, with some updating. In addition to an updated *Internal Protocol for assessing Compliance with 12VAC35-105-520 and 12VAC35-105-160.E*, dated February 2022, in August 2022, OL had created *New Hire Orientation Training for* 160, 520 and 620 with expanded examples of how Licensing Specialists should assess compliance in various scenarios. DBHDS also provided a document entitled 2022 Office of Licensing Look Behind Process for DD Providers Annual Inspections DV, dated 2/17/22, that included a protocol for the Quality Improvement Review Specialist to monitor the submissions of Attestations with CAPs for providers cited for 160.E and 520, to report the status to the appropriate Licensing Specialist and to maintain a tracking spreadsheet. As evidence of implementation of these processes, DBHDS provided a spreadsheet for a two quarter period from 1/1/22 through 6/30/22, showing 131providers that had been determined to be non-compliant with risk management requirements (as outlined in V.C.1, indicator #4) for reasons related to a lack of training. For each non-compliant provider, a tracking sheet provided the status of CAP implementation for each provider. This study also requested a sample of a 520 Attestation look-behind spreadsheet for the period between 1/1/22 through 3/31/22. For the 38 applicable providers for that quarter, 37 (97%) had evidence of CAP completion. This cured the process deficiency identified at the time of the 19th Period review.	

Compliance Indicator	Facts	Analysis	Conclusion
	DBHDS provided a spreadsheet for this review showing noncompliant providers, and a companion spreadsheet that showed the status of the corrective action plan (i.e., due date, receipt, implementation) for each applicable provider.		
32.4: 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	DBHDS provided documentation to describe its processes for determining provider compliance status with regard to CI 32.4, consistent with the processes described with regard to CI 32.4. However, DBHDS did not provide evidence to show that providers identified as noncompliant were required to demonstrate that they completed training as part of CAPs or that the CAPs were implemented.	Overall, the process analysis described with regard to CI 32.4 also applies to this CI. As evidence of implementation of these processes, DBHDS provided a spreadsheet for a two quarter period from 1/1/22 through 6/30/22, showing 138 providers that had 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). Another spreadsheet for the same period showed 151 providers noncompliant with requirements about conducting root cause analyses and required by 12 VAC 35-105-160(E). These spreadsheets did not provide any data about training requirements for a CAP, nor did the tracking spreadsheet described in the narrative for CI 32.3 address CAP status for these providers. Therefore, for this review, the evidence DBHDS provided was insufficient to show that it complied with CI 32.4.	19th Not Met **21st Not Met**

Compliance Indicator	Facts	Analysis	Conclusion
determined by the Commonwealth to be acceptable, as part of their corrective action plan process.			
32.5: 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.	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 19th 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: • Risk Awareness Tool • Risk Awareness Tool –Frequently Asked Questions • Downloadable PowerPoint Training on Specific Health Risks on the OIH webpage for specific health risks • Risk Management Training (November 2020) • Regulatory Compliance with Risk Management Regulations Training (December 2021) • Sample Provider Systemic Risk Assessment (February 2022) • Sample Provider Risk Management Plan (June 2021) • Risk Management & Quality Improvement Strategies Training by the Center for Developmental Disabilities Evaluation & Research – Handout (December 2020) • Systemic Risk Assessment Policy Template • Risk Management Policy Template • Office of Licensing (OL) Annual Checklist Compliance Determination Chart – 2022 Taken together, the written guidance and training materials addressed each of the	19th Met **21st Met**

Compliance Indicator	Facts	Analysis	Conclusion
		criteria for CI 32.05 a. through c.	
32.6: 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 nine common risks, as well as a series of Health and Safety Alerts on such topics, as well as additional relevant content. The *Risk Management Program Description, FY22,* dated July 1, 2021 – June 30, 2022, described a process for at least annual review by each office or program area with membership on the RMRC of the educational content for which they are responsible, and to	At the time of the 17th and 19th 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 various risk. For this 21st Period review, these and materials on additional risks continue to be available on the OIH webpage, including on-line guidance for the following health risks: • Aspiration Pneumonia • Constipation and Bowel Obstruction • Dehydration • Falls • Pressure Injury Training • Seizures • Comprehensive Risk Management Plan • Dysphagia • Urinary Tract Infection • Choking In addition, the OIH webpage includes other relevant content, including the following: The Importance of Annual Physicals • Risk Awareness Tool • Risk Awareness Tool – Frequently Asked Questions • Understanding the Risk Awareness Tool and Use with the WaMS v3.3 ISP • Leading Causes of Fatalities in DD – March 2022 • COVID 19 Infection Control • Infection Control Tips DBHDS also submitted evidence to show it continued to review and revise as necessary the content in this area annually, to ensure current guidance is sufficient and is included in each alert. Based on review of the *Risk Management Program Description, FY22,*	19th Met **21st Met**

Compliance Indicator	Facts	Analysis	Conclusion
	present a summary to the RMRC. The RMRC is responsible for ensuring the implementation of recommended changes. As evidence to show the review of content annually for sufficiency and/or need for revision, DBHDS submitted evidence of ongoing review, from July 2021 through April 2022, of the summary by each office program area by the RMRC.	dated July 1, 2021 – June 30, 2022, the RMRC establishes a process of educational content to determine whether that content needs to be updated on the basis of changes in policy or practice; state or federal laws or regulations; national guidelines; or surveillance or performance data reviewed by the RMRC. This process calls for each office or program area with membership on the committee to conduct a review of needed updates to educational content that addresses risk management activities at least annually. A summary of these reviews are presented to the RMRC. The content is reviewed by the identified office or subject matter expert(s), who is also responsible for recommending and implementing any changes to content. The RMRC reviews the recommended updates for content and is responsible for ensuring that annual reviews occur and are implemented. DBHDS submitted evidence of ongoing review by RMRC members and the RMRC overall from July 2021 through April 2022.	
32.7: 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	RMRC used data and information from risk management activities, including mortality reviews to identify topics for future content. Based on review of the *Risk Management Program Description, FY*22, dated July 1, 2021 –June 30, 2022, the RMRC procedures include review of surveillance data, PMIs, case	For the past two review periods, 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. At the time of the 19th Period 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. The study recommended that DBHDS should ensure it has in place a minimum set of finalized policies, procedures, instructions, protocols and/or tools needed to describe a minimum set of finalized policies, procedures, instructions, protocols and/or tools sufficient to document proper implementation of the Settlement Agreement, and, further, 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.	19th Not Met **21st Not Met**

Compliance Indicator	Facts	Analysis	Conclusion
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.	reviews, or other information that is brought to the committee to either implement improvement activities and/or develop or revise informational content that is disseminated to providers. DBHDS used risk management data and information to identify providers that are in need of additional technical assistance or other corrective action. Examples included the Incident Management Unit (IMU) daily serious incidents reviews, RMRC case reviews, RMRC tracking of tracking of the twelve surveillance measures, the Office of Clinical Quality Management (OCQM) Consultation and Technical Assistance project and the QSR HSW Alerts process.	However, for this 21st Period review, it was positive that DBHDS provided documentation that described 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. Based on review of the *Risk Management Program Description, FY2*2, dated July 1, 2021 – June 30, 2022, the RMRC procedures include review of surveillance data, PMIs, case reviews, or other information that is brought to the committee to either implement improvement activities and/or develop or revise informational content that is disseminated to providers. In summary: • Improvement activities may include implementation of a formal quality improvement initiative (QII), or mitigation activities designed to address the identified risks. Any proposed QIIs are presented to the QIC for approval and, if approved, the RMRC ensures that the QII is implemented within 90 days and reviews progress updates at least quarterly. Updates include reports on the progress of implementing interventions; review of data and whether improvement is occurring; and identification and mitigation of any barriers to success. • If the committee determines that new or additional educational or informational material is needed, members make recommendations for the type of information that may be needed. If similar information is already available, members discuss and reach consensus as to whether additional content is needed. If the determination is made to pursue additional content, the committee makes a request to the appropriate Office (whose subject matter expertise most closely aligns with the topic area). If new content development or content revision is undertaken, the designated Office will report back to the RMRC at least quarterly on progress. . This description of the process appeared to be sufficient and appropriate to the first two criteria of this CI (i.e., use data and information from risk management activities to identify topics for future content and make determinations as to when existing content needs to be revised.)	

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	However, as described with regard to CI 36.1 and 38.1, DBHDS had not yet ensured available data were valid and reliable, so the data cannot be used to confirm compliance at this time. In addition, due to problems with the CONNECT transfer with CHRIS and resulting reports, the RMRC had not reviewed serious incident reports and rates for many months	With regard to the third criterion (i.e., identify providers that are in need of additional technical assistance or other corrective action), while the *Risk Management Program Description* stated that the RMRC uses data and information to identify providers in need of additional technical assistance or other corrective action, it did not provide as clear and cohesive a description of how it did so. However, DBHDS used risk management data and information for this purpose in at least the following ways: • The Incident Management Unit (IMU) reviews serious incidents daily. As described in the *Risk Management Program Description*, as part of the triage process, the IMU reviews prior incident reports submitted for the same individual, or by the same provider to identify trends from prior history. A pattern of incidents that meets a specified threshold is identified as a "care concern" that triggers further follow-up with the provider. Individual care concerns are also forwarded to the provider's licensing specialist and to the Office of Integrated Health (OIH) who may provide follow-up technical assistance to the provider, and to the Office of Human Rights (OHR) for triage and follow-up. • The *Risk Management Program Description* notes that the RMRC might sometimes complete case reviews of a provider who has had a pattern of multiple incidents that have not been appropriately addressed or resolved, and that recommendations could include further review or technical assistance for the provider. • The *Risk Management Program Description* also notes that tracking of the RMRC twelve surveillance measures of common conditions derived from the serious incident data can identify a specific type of incident that qualifies as a concern because it is occurring at a high frequency. It goes on to note that further analysis can be conducted to identify whether there are any patterns related to specific providers or provider types with unusually high occurrences, among other factors. The document did not describe a clear next step with regard to determining the need for additional technical assistance or other corrective action and how DBHDS would address it. • The Office of Clinical Quality Management (OCQM) and the Office of Community Quality Improvement has established a tracking of the RMRC twelve surveillance measures and CTA tracking log and provides some CTA related to quality improvement and quality management processes. The	

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		identification of CTA or training needs typically comes from analysis of data and identification of trends as well as the review of provider quality improvement plans. This process began as a pilot project, focused on providers that OL identified as DD providers with an approved CAP for licensing regulation 620.C.2. Through a mailing to that target group, DBHDS offered the opportunity for up to ten providers to self-select for participation in ongoing technical assistance. On 8/5/22, DBHDS issued a report entitled *Consultation/Technical Assistance Pilot Project Report* detailing the lessons learned and the intent to expand the pilot project going forward. • As described further with regard to CI 52.6, as a part of the QSR Health, Safety, Wellbeing (HSW) Alerts process, DBHDS staff identify providers in need of technical assistance and designate staff from OIH and the Office of Provider Development (OPD) to take needed follow-up action. DBHDS staff also maintain a tracking spreadsheet to ensure and document the provision of the needed technical assistance and follow-up actions. For this 21st Period, the ability of DBHDS to implement the above procedures continued to be hampered to a significant degree by a lack of valid and reliable serious incident data, as described with regard to CI 36.1 and 38.1. As documented at the time of the 4/18/22 RMRC meeting minutes, due to problems with the CONNECT transfer with CHRIS and resulting reports, the RMRC had not reviewed serious incident reports and rates for many months. By the time of the 7/18/22 RMRC meeting, which was the last available set of minutes that referenced serious incident data, they were still not available. However, it was positive that, in the absence of the data, the RMRC had continued to review case studies in an attempt to draw possible lessons from those. For example, based on review of the RMRC meeting minutes for 4/18/22, the members reviewed a case study originally presented to the MRC with regard to an individual with Down Syndrome and a diagnosis of Alzheimer's and concluded that the facts of the case study identified a need for OIH to develop a Health and Safety Alert including additional resources specific to Down Syndrome and Alzheimer's Disease. In addition, the RMRC agreed to collaborate with the Department of Aging and Rehabilitative Services (DARS) with regard to resources from the Office on Aging and to report progress back to RMRC. Still, case reviews could not be considered an adequate	

Compliance Indicator	Facts	Analysis	Conclusion
		replacement for aggregate serious incident data as a primary means of identifying needs for training content and of providers needing technical assistance. The lack of review of serious incident data over this entire review period remained the primary deficiency that led to the rating of Not Met for this CI.	
32.8: 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.	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. 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 most recently guidance to licensing specialists in a document entitled *Office of Licensing Internal Protocol for Assessing Compliance with 12 VAC-35-105-520 and 12 VAC*	At the time of the 19th 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 21st period review, some of the resources remained current, but DBHDS had updated others and issued some new materials. The following describes the current offerings: • Flow Chart – Incident Reviews (April 2022) • Sample Root Cause Analysis Policy (February 2022) • Regulatory Compliance with Root Cause Analysis Regulations Training (December 2021) • 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 • Root Cause Analysis in Developmental Disabilities – CDDER on-line course For this 21st 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 most recently guidance to licensing specialists in a document entitled *Office of Licensing Internal Protocol for Assessing Compliance with 12 VAC-35-105-520 and 12 VAC 35-105-160(E)* in February 2022. 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	19th Met **21st Met**

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	35-105-160(E) in February 2022. In addition, DBHDS also submitted documents entitled *New Hire Orientation Training for 160, 520 and 620* with expanded examples of how Licensing Specialists should assess compliance in various scenarios and the *OL Annual Checklist Compliance Determination Chart , FY 2022*, that described the processes by which DBHDS licensing staff completed such assessments.	requirement for a Corrective Action Plan (CAP) for any cited violations including those related to conducting root cause analyses. In addition, DBHDS also submitted documents entitled *New Hire Orientation Training for 160, 520 and 620* with expanded examples of how Licensing Specialists should assess compliance in various scenarios and the *OL Annual Checklist Compliance Determination Chart , FY 2022*, that described the processes by which DBHDS licensing staff completed such assessments. Overall, the documents described a thorough process for assessing that providers adequately (in accordance with DBHDS's own guidance) identify cases for and conduct root cause analysis.	
32.9: 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	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. Based on review of the	At the time of the 19th 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: • Flow Chart – Incident Reviews (April 2022) • Sample Root Cause Analysis Policy (February 2022) • QI-RM-RCA Webinar (December 2021) • Regulatory Compliance with Root Cause Analysis Regulations Training (December 2021) • Guidance for Serious Incident Reporting – effective 11/28/20 • Final Licensing Regulations – October 2020 • Root Cause Analysis Training – October/November 2020	19th Met **21st Met**

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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.	documents provided, DBHDS guidance instructed providers how 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.	• 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 (webinar recording) • Root Cause Analysis in Developmental Disabilities – CDDER on-line course • Guidance on Corrective Action Plans – effective 8/22/20 • Risk Management & Quality Improvement Strategies – CDDER – December 2020 (slides 94-104) • Final Licensing Regulations – October 2020 (Slides 33-42) • Guidance for a Quality Improvement Program (November 2020) • Risk Management Quality Improvement Tips and Tools (June 2021) Based on review of the documents provided, DBHDS met the criteria requiring that the guidance to 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.	

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

Compliance Indicator	Facts	Analysis	Conclusion
35.1: The Commonwealth implements the Quality Improvement Plan approved by CMS in the operation of its HCBS Waivers.	As described with regard to CI 35.3, for the PMIs for which DBHDS provides data for QRT review, data that are not determined to be reliable and valid cannot be used to effectively prioritize quality improvement initiatives. At the time of the 19th Period review, the 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 49.2 (i.e., requiring DSPs and DSP Supervisors, including contracted staff, providing direct services to meet the training and core competency	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 35.3, for the PMIs for which DBHDS provides data for QRT review, data that are not determined to be reliable and valid cannot be used to effectively prioritize quality improvement initiatives. It was positive to note, though, that the End of Year (EOY) Report, revised as of August 2022 and covering the period 7/1/20 through 6/30/21, acknowledged the data reliability and validity deficiencies and discussed strategies to improve them. • The Waiver Quality Improvement Plan includes Performance Measure C9: number and percent of provider agency direct support professionals (DSPs) meeting competency training requirements. At the time of the 19th Period review, the 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 49.2 (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 49.3 (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 49.4 (i.e., requiring that at least 95% of DSPs and their	19th Not Met **21st Not Met**

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	requirements contained in DMAS regulation 12VAC30-122-180, including demonstration of competencies specific to health and safety within 180 days of hire), CI 49.3 (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 49.4 (i.e., requiring that at least 95% of DSPs and their supervisors receive training and competency testing). For this 21st Period review, assessment of this measure was assigned to the Quality Services Review process conducted by a DBHDS vendor. However, as described with regard to V.H	supervisors receive training and competency testing). For this 21st Period review, assessment of this measure was assigned to the Quality Services Review process conducted by a DBHDS vendor. However, as described with regard to V.H DBHDS has not fully developed and implemented a data analysis and reporting methodology that measures the requirements for these CIs.	

Compliance Indicator	Facts	Analysis	Conclusion
	DBHDS has not fully developed and implemented a data analysis and reporting methodology that measures the requirements for these CIs.		
35.2: 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	For CI 35.2, 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 19th 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). 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	19th Met **21st Met**

Compliance Indicator	Facts	Analysis	Conclusion
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.		remediation activities and/or to identify new or additional remediation needed. i. Processes to report progress and recommendations to the QIC.	
35.3 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,	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 35.3, sub-indicators a.	At the time of the 17th and 19th Period reviews, 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	19th Not Met **21st Met**

<table>
<tr><th>Compliance Indicator</th><th>Facts</th><th>Analysis</th><th>Conclusion</th></tr>
<tr>
<td>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>through f.

DBHDS provided a set of charts that showed the QRT demonstrated the QRT reviewed performance data for each of the measures.

However, CI 36.1 of the Settlement Agreement (SA) requires that DBHDS will not use data sources for compliance reporting until they have been found to be valid and reliable.

The Parties have agreed to a Curative Action, dated with regard to the processes DBHDS would undertake to ensure it used valid and reliable data sets for reporting compliance data for each of the CIs that included performance measures and other metrics. This process requires a Process Document that spells</td>
<td>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 DBHDS OHR Retrospective Review, no PMI or Process Document)</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, no Process Document or Attestation provided)</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 to remediate was taken. (DBHDS – Mortality Review Committee Data Tracking, no Process Document or Attestation provided)</td></tr>
<tr><td></td><td>Performance Measure G4. Number and percent of individuals who receive annual notification of rights and information to report ANE (DMAS QMR)</td></tr>
<tr><td></td><td>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/CONNECT,</td></tr>
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<td></td>
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</table>

Compliance Indicator	Facts	Analysis			Conclusion
	out a detailed methodology for data collection and reporting that takes into account any identified deficiencies with the data source system, as well as an attestation by the Office of the Chief Data Officer that the methodology in the Process Document is sufficient to produce valid and reliable data for the applicable performance measure or CI. Of the 12 waiver performance measures for which DBHDS is responsible for supplying the data, DBHDS did not provide a Process Document and/or an Attestation for the applicable data sets used for specific measures.			**no Process Document or Attestation provided**)	
				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 -OL licensing data, no Process Document or Attestation provided**)	
				Performance Measure G7. Number and percent of individuals reviewed who did not have unauthorized restrictive interventions. (**DBHDS QSR Contractor alerts, the relevant Process Document does not address the process for this measure, no Attestation provided**)	
				Performance Measure G8. Number and percent of individuals who did not have unauthorized seclusion. (**DBHDS via CHRIS – SIR, no Process Document or Attestation provided**)	
				Performance Measure G9. Number and Percent of participants 20 years and older who had an ambulatory or preventive care visit during the year. (DMAS NCQA)	
			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, no Process Document or Attestation provided**))	
				Performance Measure B2: The number and percent of VIDES (LOC) completed within 60 days of application for those for whom there is a reasonable indication that service may be needed in the future (**DBHDS -WaMS no Process Document or Attestation provided**))	

Compliance Indicator	Facts	Analysis			Conclusion
				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). (DMAS QMR)	
				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. (DMAS QMR)	
			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 QMR)	
				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. (DMAS QMR)	
				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. (DMAS QMR)	
				Performance Measure D5: Number and percent of service plans reviewed and revised by the case manager by the individual's annual review date. (DMAS QMR)	
				Performance Measure D6: Number and percent of individuals whose service plan was revised, as needed, to address changing needs. (DMAS QMR)	

Compliance Indicator	Facts	Analysis			Conclusion
				Performance Measure D7: Number and percent of individuals who received services in the frequency specified in the service plan (DMAS QMR)	
				Performance Measure D8: Number and percent of individuals who received services in the duration specified in the service plan (DMAS QMR)	
				Performance Measure D9: Number and percent of individuals who received services in the type specified in the service plan (DMAS QMR)	
				Performance Measure D10: Number and percent of individuals who received services in the scope specified in the service plan (DMAS QMR)	
				Performance Measure D11: Number and percent of individuals who received services in the amount specified in the service plan (DMAS QMR)	
				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 QMR)	
				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 (DMAS QMR)	
			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. (DMAS Claims)	
				Performance Measure C2: Number & percent of licensed/certified waiver provider agency	

Compliance Indicator	Facts	Analysis	Conclusion
		staff who have criminal background checks as specified in policy/regulation with satisfactory results. (DMAS QMR)	
		Performance Measure C3: Number & percent of enrolled licensed/certified provider agencies, continuing to meet applicable licensure/certification following initial enrollment. (DMAS QMR)	
		Performance Measure C4: Number and percent of non-licensed/noncertified provider agencies that meet waiver provider qualifications. (DMAS QMR)	
		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 QMR Provider Enrollment Form))	
		Performance Measure C6: Number of new consumer-directed employees who have a criminal background check at initial enrollment. (DMAS Fiscal Agency Reports)	
		Performance Measure C7: # of consumer-directed employees who have a failed criminal background who are barred from employment (DMAS Fiscal Agency Reports)	
		Performance Measure C8: Number and percent of provider agency staff meeting provider orientation training requirements (**DBHDS QSR, Process Document not finalized, no Attestation**)	
		Performance Measure C9: Number and percent of provider agency direct support professionals (DSPs) meeting competency training requirements. (**DBHDS QSR, Process Document not finalized, no Attestation**)	
		Performance Measure C10: Number of	

Compliance Indicator	Facts	Analysis			Conclusion
				services facilitators meeting training requirements and passing competency testing. (DMAS Training Verification Records)	
			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 QMR)	
				Performance Measure D2: Number and percent of individual records that indicate that a risk assessment was completed as required. (DMAS QMR)	
				Performance Measure D3: Number and percent of individuals whose Plan for Supports includes a risk mitigation strategy when the risk assessment indicates a need. (DMAS QMR)	
				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. (DMAS QMR)	
				Performance Measure D7: Number and percent of individuals who received services in the frequency specified in the service plan (DMAS QMR)	
				Performance Measure D8: Number and percent of individuals who received services in the duration specified in the service plan (DMAS QMR)	
				Performance Measure D9: Number and percent of individuals who received services in the type specified in the service plan. (DMAS QMR)	
				Performance Measure D10: Number and percent of individuals who received services in the scope specified in the service plan. (DMAS	

<table>
<tr><th>Compliance Indicator</th><th>Facts</th><th>Analysis</th><th>Conclusion</th></tr>
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<table>
<tr><td></td><td>QMR)</td></tr>
<tr><td></td><td>Performance Measure D11: Number and percent of individuals who received services in the amount specified in the service plan. (DMAS QMR)</td></tr>
<tr><td>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>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. (DBHDS - CHRIS/CONNECT, No Process Document or Attestation)</td></tr>
<tr><td></td><td>Performance Measure G4: Number and percent of individuals who receive annual notification of rights and information to report ANE. (DMAS QMR)</td></tr>
</table>

With regard to quarterly review of the performance measures, DBHDS provided a document entitled For this 21st Period review, DBHDS staff provided a Process Document entitled QRT DS QRT Version 002, with a revision date of 7/7/2022. However, it appeared to still be in draft form and DBHDS did not otherwise respond to requests for a formalized and final version. However, it does describe 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 draft process document continued to indicate that the QRT review 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.

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</table>

Compliance Indicator	Facts	Analysis	Conclusion
		For this review period, to demonstrate the QRT reviewed the performance measures quarterly, DBHDS provided a set of QRT meeting summaries (i.e., FY 2021 4th Qtr. QRT Meeting Summary for the 1st Quarter Meeting 3/30/202 and FY 2022 1st Qtr. QRT Meeting Summary, also for the 3/30/2022 QRT Meeting. Both documents included a chart that demonstrated the QRT reviewed performance data for each of the measures. However, CI 36.1 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. As described above in the Summary section of this study, the Parties had agreed to a Curative Action with regard to the processes DBHDS would undertake to ensure it used valid and reliable data sets for reporting compliance data for each of the CIs that included performance measures and other metrics. This process requires a Process Document that spells out a detailed methodology for data collection and reporting that takes into account any identified deficiencies with the data source system, as well as an attestation by the Chief Data Officer that the methodology in the Process Document is sufficient to produce valid and reliable data for the applicable performance measure or CI. As described above, DBHDS provided a draft version of a Process Document(i.e., *QRT DS QRT Version 002*, with a revision date of 7/7/2022). It provided some narrative with regard to the use of a new application in the DBHDS Microsoft Power Apps environment that allows each designated Subject Matter Expert (SME) to enter applicable performance measure data. Of note, while this draft Process Document is valuable in that it lays out the steps to compile the data reports into the EOY Report in a consistent manner, it does not address the requirements for a methodology for obtaining valid and reliable data from each of the data sets that underly what the respective SMEs enter into the Power Apps application. To achieve this would require a specific Process Document methodology and an approved Attestation for each of the data sets the SMEs relied upon. However, in the chart above, there are 12 performance measures for which DBHDS did not provide a finalized Process Document and/or an Attestation for the applicable data sets used for the specific measures. In addition, based on the findings for CI 36.1 and CI	

Compliance Indicator	Facts	Analysis	Conclusion
		38.1 below, for those measures for which DBHDS provided performance data from CHRIS (or its successor, CONNECT), DBHDS had not yet determined that the data were valid and reliable and, therefore, may not be used for compliance reporting. In summary, for the performance measures for which DBHDS was responsible, data were being collected, but the data had not yet been determined to be valid and reliable. At the time of the previous review, the study also found the performance measures delegated to DMAS did not have data definitions and data collection methodologies were not sufficient to ensure data reliability. However, for this review, it was positive that DMAS provided Process Documents that generally provided a glossary of terms and defined the data source and a methodology. These appeared to be adequate, but are not subject to the Attestation process. The topics covered in the DMAS Process Documents included the following: • Consumer Directed Employees • Contract Evaluation • Criminal Record Check • NCQA Data • Orientation and Competencies • Plan Development • Provider Criteria • Provider Enrollment • Service Facilitator Training Requirements • VIDES Choice Risk Assessment • Waiver Claims	
35.4: The performance measures are found in the published DD HCBS waivers found at cms.gov and are posted on the DBHDS website.	The waiver performance measures are found in the published DD HCBS waivers found at cms.gov. DBHDS had posted on its website the QRT End of Year (EOY) report, which	For this review, the study confirmed that the waiver performance measures are found in the published DD HCBS waivers found at cms.gov. In addition, DBHDS had posted the SFY21 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.	19th Met **21st Met**

Compliance Indicator	Facts	Analysis	Conclusion
	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.		
35.5: 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	DBHDS provided two sets of QRT meeting summaries that demonstrated the QRT reviewed performance data for each of the measures. DBHDS also provided a video of a QRT meeting held on… 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 summaries for some measures that	At the time of the 17th and 19th Period reviews, the respective studies 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 meeting summaries designated as FY 2021 4th Qtr. QRT Meeting Summary for the 1st Quarter Meeting 3/30/202 and FY 2022 1st Qtr. QRT Meeting Summary, also for the 3/30/2022 QRT Meeting, that demonstrated the QRT reviewed performance data for each of the measures. These minutes included reporting on remediation plans, but these continued to focus primarily on individual provider remediation. Overall, as previously reported, 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 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."	19th Not Met **21st Not Met**

Compliance Indicator	Facts	Analysis	Conclusion
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	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.	While a systemic focus was not often evidenced in the quarterly proceedings, the SFY 21 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 and therefore were not sufficient. In addition, as described for CI 35.7 below, this report covered a period from 7/1/20 through 6/30/21, so it was impractical to use the information for any comparative purposes to current year activities. Based on the findings for CI 36.1 and CI 38.1 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.	
35.6: 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.	At the time of the 17th and 19th Periods, 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.	19th Not Met **21st Met**

Compliance Indicator	Facts	Analysis	Conclusion
	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 49.2, CI 49.3 and CI 49.4. DBHDS provided a document entitled *DMAS Provider Review Unit Policy Manual* that provided a detailed description of the annual audit plan and processes. It demonstrated that DMAS conducted financial auditing consistent with the methods, scope and frequency of audits approved by CMS.	• 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. At the time of the 19th Period study, an in-depth examination of DMAS oversight of provider staff competencies 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 49.3 (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). For this review, pursuant to a Curative Action filed with the Court on 11/19/21, the Parties agreed to process changes with assignment of responsibility for assessment of providers' implementation of the training and core competency-based training program from the DMAS QMR process to a more specifically designed assessment incorporated into the QSR process conducted by a DBHDS vendor. The revised process began in November, 2021, with the third round of QSR reviews. Based on the findings of this 21st Period review of Provisions V.H.1 and V.H.2, this method of assessing competence of the DSP/DSP Supervisor workforce competency is much improved over previous processes. Also, at the time of the previous review, 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. For this review, DBHDS provided a document entitled *DMAS Provider Review Unit Policy Manual* that provided a	

Compliance Indicator	Facts	Analysis	Conclusion
		detailed description of the annual audit plan and processes.	
35.7: 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.	For the 19th Period review, the QRT's most recent approved End of Year (EOY) Report covered period 7/1/19 through 6/30/20, noting that it was effective as of 9/27/21. For this review, DBHDS provided an *EOY Report*, revised as of August 2022 and covering the period 7/1/20 through 6/30/21. This met the standard for being completed on an annual basis. However, the *EOY Report* data were approximately more than 14 months old and therefore were not adequate or useful for CSB quality improvement committees to establish CSB-specific quality improvement activities Based on the draft	For the 19th Period review, the QRT's recent approved End of Year (EOY) Report covered period 7/1/19 through 6/30/20, noting that it was effective as of 9/27/21. For this review, DBHDS provided an EOY Report, revised as of August 2022 and covering the period 7/1/20 through 6/30/21. This met the standard for being completed on an annual basis. However, it continued to be problematic 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. Reports with data that are approximately 14 months old are not adequate or useful for CSB quality improvement committees to establish CSB-specific quality improvement activities and not sufficient to fulfill the requirements of this indicator. Of note, in a video of a QRT meeting for the period…, the presentation indicated that DBHDS Leadership had requested that the QRT publish its next EOY Report within four months of the conclusion of and SFY. The QRT agreed to make its best effort to do this. This may require modifications to the draft Process Document timelines for this process. The remaining requirements for CI 35.7 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 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. Based on interview with the QRT Manager, for the most recent EOY Report, DBHDS received responses to the survey from 38 of 40 CSBs, which was a significant improvement from the 19th Period, when only 27 of 39 CSBs responded. As reported	19th Not Met **21st Not Met**

Compliance Indicator	Facts	Analysis	Conclusion
	Process Document submitted for review, the finalized QRT End of Year (EOY) Report was 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 38 of 40 CSBs. Based on the findings for CI 36.1 and CI 38.1 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.	previously, the draft Process Document did not specify any action DBHDS would take for non-compliance and the study recommended that DBHDS should update that document to specify action(s) DBHDS would take for CSB non-compliance with annual review of performance measures. In addition to issues with timeliness of reporting, based on the findings for CI 36.1 and CI 38.1 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.	
35.8: The Commonwealth ensures that at least 86% of individuals who are assigned a waiver slot are enrolled in a service within	DBHDS provided two *Case Management Steering Committee Semi-Annual Reports* with data from SFY 2019 and SFY	At the time of the 19th Period, the study found that 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. For this 21st Period review, DBHDS provider the last two Case Management Review	19th Not Met **21st Met***

Compliance Indicator	Facts	Analysis	Conclusion
5 months, per regulations.	2020 indicating that at least 86% of individuals who were assigned a waiver slot were enrolled in a service within 5 months, per regulations, for those time periods (91.5% and 86.1% respectively). The most recent *Case Management Steering Committee Semi-Annual Report for SFY 2021*, 3rd and 4th Quarters, dated 10/29/21 and edited 11/18/21, stated that more recent annual results for this measure were not available at that time because it required additional time following the end of the FY for data collection and reporting. DBHDS did not provide evidence of an approved data collection methodology to ensure	Committee reports (i.e., *Case Management Steering Committee Semi-Annual Reports* for SFY 2021, 1st and 2nd Quarters, dated 3/22/21 and SFY 2021, 3rd and 4th Quarters, dated 10.29.21 and edited 11.18.21). Based on review of the report for the 1st and 2nd Quarters, the last available data was for SFY 2019 and indicated achievement of 96.1%. The report for the 3rd and 4th Quarters stated in the narrative that the most recent report from FY 2020 indicated the result was 88%, as shown in Figure 15. It appeared this was inaccurate, as Figure 15 reflected a different measure (i.e., Individual Support Plans are available in the Waiver Management System by direct keyed entry or data exchange since October 7, 2019.) It further appeared that Figure 14 reflected the data for the percentage of individuals who are assigned a waiver slot are enrolled in a service within 5 months, which was 86.1%. However, DBHDS did not provide any information about the methodology for valid and reliable data for deriving this measure. The following describes concerns noted: • The *Case Management Steering Committee Semi-Annual Reports* stated that the measure was derived from the numerator "Number of individuals authorized for one or more DD waiver services within 5 months of enrollment" and the denominator "Number of individuals enrolled in a DD waiver." However, the reports did not provide any other information about the data sources from which the numerator and denominator were derived. • DBHDS submitted several versions of a Process Document entitled *DD CMSC Data Review*, including version 001, dated 7/13/21, version 002, dated 10/15/21 and at least three additional drafts of the Process Document with dates of 11/13/21, 6/8/22 and 9/16/22. However, it appeared the most recent final version was the one dated 10/15/21. The only version that indicated the Process Document referenced CI 35.8 was the draft dated 9/16/22, but it otherwise included no information about how the measure was to be derived. • The most recent attestation related to the *DD CMSC Data Review* was dated 8/9/22 and therefore could not have addressed any methodology for this CI. • The Process Document entitled *QRT DS QRT Version 002*, with a revision date of 7/7/2022 that appeared to still be in draft form. In any event, it did not include this CI as one of the applicable provisions. In addition, the *Case Management Steering Committee Semi-Annual Report* for SFY 2021, 3rd	

Compliance Indicator	Facts	Analysis	Conclusion
	valid and reliable data for this measure, in any of the current *Case Management Steering Committee Semi-Annual Reports,* the *QRT EOY Report* or the *DD CMSC Data Review* Process Document	and 4th quarters, indicated the annual results for this measure were not available at that time because it required additional time following the end of the FY for data collection and reporting. DBHDS, DMAS and the CMSC should consider completing quarterly tracking of this measure, similarly to the other waiver performance measures, particularly in light of the decreased performance between SFY 2019 (96.1%) and SFY 2020 (86.1%).	

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
36.1: 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		Previous studies have documented the steps DBHDS, and the Office of EHA in particular, have taken to address this CI. They had issued several iterations of the *Data Quality Monitoring Plan*, beginning in the Fall of 2019, and 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 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.	19th Not Met **21st Not Met**

Compliance Indicator	Facts	Analysis	Conclusion
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.		During the 19th Period review, DBHDS acknowledged that it 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*, including 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. Overall, these documents described what appeared to be a sound process by which the Office of EHA would complete an annual update for each of the data sources systems, and a process by which DBHDS would phase in broader re-assessments for each of the sources systems included in the original *Data Quality Monitoring Plan*. As an output of this process, the Office of DQV planned to identify up to twelve actionable recommendations for each system, that, if completed, would result in the greatest improvement to data validity and reliability. As described at the time of the 20th Period review, on 1/21/22 the Parties jointly filed with the Court an agreed-upon Curative Action regarding data reliability and validity that memorialized this process as a set of actions DBHDS would implement going forward. This Curative Action (i.e., Curative Action for Data Validity and Reliability) is also summarized in the Summary of this report above. **Source System Assessment:** One element of this document requires that the Office of DQV continue to complete source system updates and assessments as described in the data quality monitoring documents referenced for the 19th Period review. The following provides a summary of the most pertinent documents provided for review for this 21st Period: • *Data Quality Monitoring Plan Source System Annual Update:* This DBHDS document, dated June 2022, is an annual update produced using the methodology described in the *Data Quality Monitoring Plan: Annual Update Process,* dated April 2021. 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 systems 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 improvements listed in this report are outlined further with regard to CI 38.1 below. Overall, DBHDS	

<table>
<tr><th>Compliance Indicator</th><th>Facts</th><th>Analysis</th><th>Conclusion</th></tr>
<tr><td></td><td></td><td>did not attest to the full remediation of any of the data source systems. Further, the Source System Annual Update stated that additional efforts were needed to sufficiently address data quality as outlined in the original Data Quality Monitoring Plan report.

The chart below summarizes areas of improvement identified during this past year but also highlighted the evolving status of the source systems overall. Of note, since the last review, OLIS had transitioned to CONNECT, but additional systems were also slated for replacement. According to this current version of the Source System Annual Update, in June 2021, agency leadership found that CHRIS-SIR, CHRIS-HR, and PAIRS were no longer able to adapt to meet the needs of the agency and decided that a replacement system would be necessary to usurp the functionality of these systems. The agency plans to replace these three systems with a unified Incident Management system, and as a result, will only amend the original systems with a focus on maintaining the systems until the time in which a replacement has been procured and integrated into the agency workflow. Currently, the Incident Management system project is in the procurement phase and has no defined target completion date. In addition, the Business Owners for the Electronic Mortality Review Form (eMRF) effort to replace the Children in Nursing Facilities indicated they are currently working to replace those systems. At the time of the previous review, the Source System Annual Update stated that no replacement was pending for Avatar; however, the current update indicates a replacement is pending.

<table>
<tr><th>Source System</th><th>Categories of improvement</th><th>Replacement Status</th></tr>
<tr><td>Avatar</td><td>Key Documentation, Data Validation, User Interface, Business Ownership, Maturity</td><td>Planned replacement</td></tr>
<tr><td>Children in Nursing Facilities Spreadsheet</td><td>User Interface</td><td>Planned replacement</td></tr>
<tr><td>CHRIS-OHR/SIR</td><td>Data Validation, User Interface, Maturity</td><td>Planned replacement</td></tr>
</table></td><td></td></tr>
</table>

Compliance Indicator	Facts	Analysis	Conclusion

Employment Spreadsheet	Key Documentation, User Interface, Data Validation, Maturity	N/A
IFSP – Individual and Family Support Program	None	Planned integration
eMRF – Electronic Mortality Review Form	None	Planned replacement
OLIS – Office of Licensing Information System / Transitioned to **CONNECT***	Key Documentation, Data Validation, User Interface, Business Ownership, Maturity	Complete
PAIRS - Protection and Advocacy Incident Reporting System	None	Planned replacement
REACH - Regional Educational Assessment Crisis	Key Documentation, Data Validation, User Interface, Business Ownership, Maturity	In transition to Crisis Data Platform

Of note, the *Source System Annual Update* did not address QSR. The *DBHDS Response to DQMP Recommendations*, dated 8/2/22, noted a previous DQMP recommendation stating that QSR was in need of a source system assessment. However, in interviews for this study, the Director of DQV (aka EHA) stated that QSR does not meet the definition of a source system. In addition, the Senior Director of Clinical Quality Management stated that the QSR was not a source system, but simply a tool to collect data.

The Parties agreed, and on 1/21/22 informed the Court, that a source system was defined as the electronic systems, applications or spreadsheets that the Department uses to pull data sets required for reporting purposes.

The DBHDS document entitled *Source System Roles and Responsibilities*, dated August 2022, defines a source system in the following manner: A source system is defined as

Compliance Indicator	Facts	Analysis	Conclusion
		any data source used across DBHDS that meets the following criteria: 1) It is the primary point of original electronic data entry. 2) Contains linkage information, for the data elements that originate outside the system, which enable data to be refreshed. 3) Captures and preserves consistent historical records on discrete individuals, Incidents, events, or organizations allowing re-creation of the data at a point in time. 4) Reflects the entirety of collected data from a population, and 5) Has a business owner. DBHDS did not provide a specific answer when asked in writing to explain why the QSR did not meet the criteria included in this internal definition of a source system or explain why it was not the same as the definition the Parties filed with the Court. The *DBHDS Response to DQMP Recommendations* noted that DBHDS and QSR Contractor staff completed an *External Data Validation Checklist.* However, this could not take the place of a source system assessment, as required by the Curative Action. The document notes that, among the limitations of the checklist is the fact that there is currently no way to validate whether the checklist is an objective measure of the validity and reliability of external data sources. None of the items were independently validated using objective standards and EHA has yet to devise a scoring system for the checklist, and therefore does not have a way to determine whether every item on the checklist applicable to the vendor should be marked "Yes" in order to confirm the validity and reliability of the data source. Given that QSR is the basis for measuring compliance not only for many provisions, but also for several Curative Actions, using only a tool that cannot assure it is an objective measure of validity and reliability is not sufficient. The Commonwealth did not provide sufficient records to document that the validation requirements in indicator 36.1, regarding the QSR data it provided for compliance determinations. • *Reassessment with Actionable Recommendations, August 2022:* This document reiterated the expectations for the re-assessment process described in the earlier version. Based on interview with DBHDS staff, this process began with evaluations of AVATAR and the Children in Nursing Facilities Spreadsheet. In addition, by the time of 21st Period	

Compliance Indicator	Facts	Analysis	Conclusion
		review, the Office of DQV had also completed reviews for the Comprehensive Employment Spreadsheet and WaMS. Based on interview with DBHDS staff, there is not a formal queue for the next reassessments, but they expect the next reviews to likely be for the RST and IFSP source systems. The document also noted that DQV will not perform assessments on any source systems that are in the process of being replaced. A full assessment of these systems will be delayed until a replacement system has been fully implemented and is stable. As indicated in the chart above, this includes at least five of the source systems. While the first four reassessments have not yet resulted in a finding that a source system is fully reliable, the document describes a process for continued follow-up to track whether all completion criteria have been achieved and that all threats to data quality have been sufficiently resolved. Upon such resolution the Director of the Office of DQV will inform the Quality Improvement Committee and respective subcommittees of this finding. This communication will assert that, as of the date that the Follow-up assessment was completed, there are no significant threats to data validity and reliability that would affect the data within that system for subsequent reporting periods; providing that no future upgrades or enhancements pose novel threats to data quality within the system. **Data Set Validity and Reliability:** A second element of the Curative Action for Data Validity and Reliability entails confirming the validity and reliability of specific data sets and their use in producing data for compliance reporting. While the confirmation process itself is outside the provenance of the Office of EHA, that office continues to be responsible for identifying the threats to data validity and reliability in the data collection methodologies. The Curative Action then describes the process for documenting (i.e., through a Process Document) how any threats to validity and reliability for the specific data set can be remediated for each applicable purpose. The Process Document must describe the data set to be used, a methodology for addressing any threats to validity and reliability of the data available in the data set, and a methodology for addressing any threats to validity and reliability in the process of pulling the data from the data set. Once this is complete, the office of the CDO completes a review and attests that the process will produce valid and reliable data.	

Compliance Indicator	Facts	Analysis	Conclusion
		For this 21st Period, it was positive to see that the Office of EHA had completed an annual assessment of the data collection methodologies for each active PMI and identified threats, if any, to the data validity and reliability. However, based on a review of the available Process Documents and Attestations, DBHDS could not yet reliably attest to the use of many of the applicable data sets for the PMIs. In some instances, this was due to known defects that had not been cured or remediated. For example, DBHDS was aware that, for PMIs that derived data from CHRIS/CONNECT, it could not yet attest that the data were valid and reliable. Based on a presentation by the Office of EHA, dated 3/17/22, entitled *Requested Modifications: CHRIS, An Overview of Identified Data Quality Issues and Possible Solutions*, existing issues included the following: • Uncertainty about scope of possible changes • Duplicate Consumer IDs within a single provider • Duplicate Consumer IDs across providers (lack of unique identifier) • (Lack of) a List of all licensed services with diagnosis categories • Inconsistent service program identification • Lack of data for CHRIS outages • Fix data exchange related to serious incidents/ANE allegations The Office of EHA indicated the issues outlined above, while not the product of a complete source system review of CHRIS, represented clear barriers to sustainable data reporting and analysis tasks required by the SA Compliance Indicators for the Office of Licensing, the Office of Human Rights, and the Risk Management Review Committee. In addition, the presentation noted that these might not be the most severe data quality issues within CHRIS and were certainly not the only threats to data validity or reliability within that system. These issues impacted at least three PMIs (i.e., annualized rates of "falls" or "trips;" seclusion or restraints only utilized after less restrictive interventions; and critical incidents are reported on time. The following describes examples of other concerns noted: • DBHDS did not provide either Process Documents or Attestations for the following PMIs:	

Compliance Indicator	Facts	Analysis	Conclusion
		○ Annualized rates of "falls" or "trips" ○ CEPPs are completed within 15 days ○ Individuals have stability in independent housing ○ Individuals live in independent housing • DBHDS provided Process Documents, but not Attestations for the following PMI: ○ Individuals who chose or had some input in choosing where they live • DBHDS sometimes provided attestations for PMIs, but the attestation dates were prior to the current version of the PMI. DBHDS should create a protocol to determine how revisions to Process Documents will be screened to determine whether the revisions might impact the accuracy of the existing Attestation. This impacted numerous measures and PMIs. ○ Seclusion or restraints only utilized after less restrictive interventions ○ RST timeliness of non-emergency referrals ○ For the Process Document for the Provider Data Summary, the Attestation was completed on 3/7/22, which would have corresponded to *Version 001*, although there was a *Version 002*, dated 9/8/22. Overall, in this instance, it appeared both versions included the same steps for compiling each of the eleven measures into the report. Based on review of the two versions, they appeared to be fundamentally the same. ○ DBHDS submitted several versions of a Process Document entitled *DD CMSC Data Review*, including *Version 001*, dated 7/13/21, *Version 002*, dated 10/15/21 and at least three additional drafts of the Process Document with dates of 11/13/21, 6/8/22 and 9/16/22. However, it appeared the most recent final version was the one dated 10/15/21. The most recent attestation related to the DD CMSC Data Review was dated 8/9/22. However, it was not possible to ascertain which version of the Process Document was reviewed in order to complete the Attestation. • As described with regard to the Attestations for CIs 14.2,14.3, 14.4, 14.5, 14.6, and 14.7 did not include the creation of a sample data set. As a result, the Independent Reviewer's consultant could not complete the necessary spot-check	

Compliance Indicator	Facts	Analysis	Conclusion
		for verification. • While Process Documents often provided methodologies for how to pull data from the data set, they typically did not identify and address how to address threats to reliability and validity based on deficiencies that potentially emanated from data entry.	
36.2: 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 36.1 and for CI 36.5 and CI 38.1 below with regard to data quality, DBHDS	Based on review of documentation submitted, including meeting minutes from the QIC, RMRC, MRC, CMSC and the KPA Workgroups, DBHDS continued to use 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 36.7 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. However, as described above for CI 36.1 and CI 38.1 below with regard to data quality for the source systems, DBHDS had not yet ensured the data used for analysis was reliable. Therefore, the data cannot be used for the purpose of compliance reporting.	19th Met* **21st Met***

Compliance Indicator	Facts	Analysis	Conclusion
	had not yet ensured the data used for analysis was reliable. Therefore, it cannot be used for the purpose of compliance reporting.		
36.3 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 this 21st Period review, DBHDS and VCU staff met monthly to discuss sampling procedures and other logistical concerns, but did not otherwise review specific data related to the quality of services and individual level outcomes to identify potential service gaps or issues with the accessibility of services. Based on a review of QIC presentations and minutes for the most recent four quarters available for review, the QIC did not review NCI data or make strategic improvement recommendations.	**NCI:** At the time of the previous reviews, DBHDS and VCU staff continued to provide National Core Indicators (NCI) data to the QIC for review on an annual basis for consideration of strategic improvement recommendations. For this 21st Period review, DBHDS and VCU staff met monthly to discuss sampling procedures and other logistical concerns, but did not otherwise review specific data related to the quality of services and individual level outcomes to identify potential service gaps or issues with the accessibility of services. Based on a review of QIC presentations and minutes for the most recent four quarters available for review, it was not documented that the QIC met the requirements of this indicator by reviewing NCI data or making strategic improvement recommendations. **QSR:** At the time of the 19th Period review, DBHDS staff provided second round Quality Services Review data to the QIC for review. For this review period, 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 this 21st Period review, this remained the most recent substantive presentation of QSR data to the QIC submitted for review. 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.	19th Not Met **21st Not Met**

Compliance Indicator	Facts	Analysis	Conclusion
	The only substantive review of QSR data by the QIC provided for review was in September 2021. 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.	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 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. For this review, DBHDS provided QIC minutes for the meeting held on 9/27/21. As described with regard to CI 52.4 in this report, which included a comparison of Round 1 and Round 2 findings and a description of opportunities for improvement. QSR recommendations to the QIC were often stated in very broad terms, which made them difficult to use to inform quality improvement efforts. On 12/13/21, the subcommittees responded to the recommendations made at the meeting on 9/27/21. Many of the responses reported on related work already underway, rather than on requests for additional or specific data that might allow the development of a more focused quality improvement effort. One notable exception to the latter was the RMRC response to the QSR recommendation that protocols for physical and behavioral risks are documented and that ISPs are revised to include outcomes and supports for individuals' risks of harm. The RMRC responded that they would like additional information to further understand how to best address this recommendation, noting that a study of the initial implementation of the fall prevention QII found that 74% of individuals with fall	

<table>
<tr><th>Compliance Indicator</th><th>Facts</th><th>Analysis</th><th>Conclusion</th></tr>
<tr><td></td><td></td><td>risk in RAT had additional supports incorporated into the ISP.

Overall, though, as the process continues to mature, it would appear that DBHDS has a process in place to review and analyze the results for meaningful quality improvement.

However, at the current time, based on the lack of DBHDS confirmation that the QSR produced valid and reliable data, as described in more detail with regard to 38.1, the QSR data cannot be used to fully and reliably evaluate the quality of services and individual level outcomes, the identification of potential service gaps or issues with the accessibility of services, or any resulting strategic improvement recommendations.</td><td></td></tr>
<tr><td>36.4: 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</td><td>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 36.1 above and CI 38.1 below with regard to data quality, DBHDS had not yet ensured the data used for analysis</td><td>At the time of the 19th period review, DBHDS provided a Departmental Instruction 316 (QM) 20, Quality Improvement, Quality Assurance, and Risk Management for Individuals with Developmental Disabilities (DI 316), dated 04/7/21. It described the QIC subcommittee and KPA workgroup functions in a manner that was consistent with the requirements of CI 36.4. Based on the documentation provided for this 21st Period review, this document remained current.

For this review, DBHDS provided documentation indicating it currently had six measures for the Health, Safety and Well-being domain (i.e., two for Safety and Freedom from Harm, three for Physical, Mental and Behavioral Health and one for Avoiding Crisis); eight outcome measures for Community Inclusion and Integration (i.e., three for Stability, three for Choice and Self-Determination and two for Community Inclusion); and, ten measures for Provider Competency and Capacity (i.e., - six for Access to Services and four for Provider Capacity). The table below show each of these measures, organized by domain.
<table>
<tr><th>Domain</th><th>Subcommittee/ Workgroup</th><th>PMI</th></tr>
<tr><td>Safety and Freedom from Harm</td><td>RMRC</td><td>Annualized rates of "falls" or "trips" are 56.88 or less</td></tr>
</table></td><td>19th Not Met

21st Met*</td></tr>
</table>

Compliance Indicator	Facts	Analysis					Conclusion
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).	was reliable. Therefore, it cannot be used for the purpose of compliance reporting.		Safety and Freedom from Harm	KPA Workgroups	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.		
			Physical, Mental and Behavioral Health and Well-being	KPA Workgroups	Individuals on the DD waivers will have a documented annual physical exam date.		
			Physical, Mental and Behavioral Health and Well-being	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.		
			Physical, Mental and Behavioral Health and Well-being	CMSC	Individual support plans are assessed to determine that they are implemented appropriately.		
			Avoiding Crisis	KPA Workgroups	Individuals who are admitted into REACH mobile crisis supports will have a CEPP completed within 15 days of their admission into the service.		
			Stability	KPA Workgroups	Individuals on the DD waivers and waitlist are working in Individual Supported Employment (ISE) and Group Supported Employment (GSE) for 12 months or longer.		
			Stability	KPA Workgroups	Individuals have stability in the independent housing setting.		

Compliance Indicator	Facts	Analysis				Conclusion
			Stability	KPA Workgroups	Individuals with a DD waiver and known to the Reach system who are admitted to CTH facilities will have a community residence identified within 30 days of admission.	
			Choice and Self-Determination	KPA Workgroups	At least 75% of individuals who do live in the family home chose or had some input in choosing where they live.	
			Choice and Self-Determination	CMSC	Individuals participate in an annual discussion with their Support Coordinator about relationships and interactions with people (other than paid program staff).	
			Choice and Self-Determination	CMSC	Individuals are given choice among providers, including choice of support coordinator, at least annually.	
			Community Inclusion	KPA Workgroups	Individuals live in independent housing.	
			Community Inclusion	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.	
			Provider Capacity	RMRC	Critical incidents are reported to the Office of Licensing within the required timeframe (24 hours).	

Compliance Indicator	Facts	Analysis					Conclusion
			Provider Capacity	RMRC	Percentage of licensed providers, by service, that were determined to be compliant with 100% of the risk management regulations that were able to be reviewed during their annual inspection.		
			Provider Capacity	RMRC	86% 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.		
			Provider Capacity	KPA Workgroups	People with DD waiver are supported by trained, competent Direct Support Professionals.		
			Access to Services	KPA Workgroups	Data continues to indicate an annual 2% increase in the overall DD waiver population receiving services in the most integrated settings.		
			Access to Services	KPA Workgroups	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.		
			Access to Services	KPA Workgroups	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.		
			Access to Services	CMSC	Individuals receiving case management services from the CSB whose ISP, developed or updated at the annual ISP meeting, contained integrated community involvement outcomes.		

Compliance Indicator	Facts	Analysis	Conclusion

Access to Services	CMSC	Adults (aged 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.
Access to Services	CMSC	Regional Support Team (RST) non-emergency referrals are made in sufficient time for the RSTs to meet and attempt to resolve identified barriers.

Of note, for this review, the Risk Management Review Committee, Case Management Steering Committee, and Key Performance Area (KPA) workgroups, all established goals and monitored progress towards achievement through the creation of specific KPA Performance Measure Indicators (PMI). The Mortality Review Committee (MRC) did not establish any PMI during this period; however, the MRC did implement and monitor QIIs in the following domains: Health, Safety and Well-being (i.e., decrease COVID-19 mortality rate) and Provider Competency and Capacity (i.e., increased opioid overdose training for providers, reduction in crude mortality level for SIS level 6 and increased adherence to medical emergency protocols).

At the time of the 17th and 19th Period reviews, 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 staff still sometimes 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

Compliance Indicator	Facts	Analysis	Conclusion
		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 studies recommended that DBHDS revisit the designation of measures as output vs. outcome. For this 21st Period review, in most instances, it appeared DBHDS staff had applied a correct designation. However, as previously reported 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. While this did not impact overall compliance, DBHDS should again revisit the designation of measures as output vs. outcome. Based on the findings for CI 36.1 and CI 38.1, for many of the applicable data sets, DBHDS had not yet determined they produced valid and reliable data, so the data cannot be used to support compliance findings.	
36.5: 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.	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*, updated as of 7/26/21, accompanied by a Measure Development Template, for use by DBHDS staff for measure development. For this review, the Office of DQV had revised the *Technical Guidance for Measure Development* as of 8/22/22. Overall, the guidance addressed each of the requirements of 36.5, as follows: • Measure Steward: Each PMI has a measure, or data, steward. This is the team member assigned to report and enter data for their respective PMI(s). • 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 methodology for collecting reliable data. This is a complete and thorough description of the specific steps used to supply the numerator and denominator for calculation. a. who will collect the data (e.g., office, team, individual),	19th Not Met **21st Met**

Compliance Indicator	Facts	Analysis	Conclusion
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.		b. 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 outline relevant parameters (e.g., inclusion codes), and c. when or 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.) d. Calculation Steps: Outline of the specific steps necessary to calculate results for the PMI, with emphasis on obtaining a numerator and denominator. Whenever the PMI uses a sampling framework, the sample size, confidence interval, and margin of error shall also be reported. As described in detail for CI 36.1, in contrast to the findings of the 19th Period review, it was positive to see that for this 21st Period review, PMIs typically did have completed data collection methodologies. In addition, it was positive that the Office of DQV (aka EHA) had typically completed the recommendations section and documented a current review, either annually, or as needed to address modifications to the methodology the Data Steward had made. This was an improvement over the previous reporting period. • Regional Breakdown: A Yes/No indicator to show whether the measure can provide regional data breakdowns. • Population: A description of the population described in the denominator. • Target & Timeline: The target and data that represents where the results should fall at or above. • Baseline: The baseline or benchmark data, as available. • Business Definitions & Processes: Definition of terms included in the PMI.	

Compliance Indicator	Facts	Analysis	Conclusion
		• Recommendations: Once a Measure Steward completes the PMI form and there is comprehensive information in each section, the Measure Steward seeks a review and consultation with staff from the Office of Epidemiology and Health Analytics to identify any potential issues or concerns with the measure language, or to assess for any potential threats to data quality in the measure methodology and calculation steps. This section will preserve and communicate those concerns back to the Measure Steward, as well as any recommendations to remedy those concerns. The Measure Steward must provide a written response that includes a plan of action to remediate the concern or strategy to mitigate the risk in the future. • Reference: The Settlement Agreement Indicator, as applicable, and the current DBHDS Metric.	
36.6: 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	DBHDS was using a system for tracking PMIs as described in the *Quality Management Plan*. 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	DBHDS was using a system for tracking PMIs as described in the *Quality Management Plan SFY 2021.* The plan described procedures to track the efficacy of preventative, corrective, and improvement measures. In addition, CI 36.2, CI 36.4 above and CI 36.7 below provide examples with regard to how DBHDS quality committees and workgroups currently use this information with its QIC to identify areas of needed improvement at a systemic level and to make and implement recommendations to address them. As reported at the time of the 19th Period review, DBHDS had implemented a modified approach to reviewing the efficacy of preventative, corrective, and improvement measures, and developing and implements preventative, corrective, and improvement measures. This new approach was intended to acknowledge that subcommittees and workgroups often have PMIs that cross over the assigned domains (i.e., as illustrated in the charts for CI 31.6 above.). As a result, the new concept focuses reporting on the KPA domain, including relevant PMIs from all applicable committees and workgroups, as well as NCI and QSR findings, and bring it all together in one place to facilitate a comprehensive discussion and answer the question 'How are we doing in this KPA?' Overall, this was a well-thought out strategy and held promise for enhancing an	19th Not Met **21st Met***

Compliance Indicator	Facts	Analysis	Conclusion
of needed improvement at a systemic level and makes and implements recommendations to address them.	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 36.1 and CI 38.1, the data reviewed cannot be confirmed to be valid and reliable and cannot be used for compliance reporting.	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 36.1 above and CI 38.1 below, the data reviewed cannot be confirmed to be valid and reliable and cannot be used for compliance reporting.	
36.7: DBHDS demonstrates annually at least 3 ways in which it has utilized data collection and analysis to enhance outreach, education, or training.	For this 21st Period review, at the QIC meetings for the third and fourth quarters of SFY22, DBHDS subcommittees and workgroups offered PowerPoint presentations that described numerous ways in which they used data collection and analysis to enhance outreach, education, or training.	At the time of the 19th 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. For this 21st Period review, at the QIC meetings for the third and fourth quarters of SFY22, DBHDS subcommittees and workgroups offered PowerPoint presentations that described ways in which they used data collection and analysis to enhance outreach, education, or training. Examples are provided below. • The RMRC reported the following examples: o The Office of Integrated Health has conducted a number of trainings related to risks common in individuals with developmental disabilities: Urinary tract infection prevention, Sepsis training; Fatal seven training. o Office of Community Quality Improvement / Licensing conducted pilot technical assistance –assisting providers in developing measurable goals and objectives (10 providers). o The Office of Licensing provided training on 'Individual and Systemic	19th Met* **21st Met***

Compliance Indicator	Facts	Analysis	Conclusion
	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 36.1 above and CI 38.1 below, the data reviewed cannot be confirmed to be valid and reliable and cannot be used for compliance reporting.	Risk: How to Report and Respond to Serious Incidents' (April 28, 2022). • The CMSC reported the following examples: o At the request of Regional Quality Councils, data was displayed at the regional level so that comparisons could be made by Council members. o Collaboration with RST members statewide resulted in the aggregation and theming of referral barriers into a Pareto Chart, so that action could be planned and taken. o The CMSC now provides row level data regarding ISPs and ISP compliance, so that CSBs can undertake the ongoing review of their performance in multiple areas. • The KPA Workgroups reported the following examples: o Updated the SCQR Tool (Community Engagement/Employment and created training around the same. o Created new FAQ on Community Engagement/ Employment o Reconstituted the Community Engagement Advisory Group to address barriers relayed to community inclusion. 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 36.1 above and CI 38.1 below, the data reviewed cannot be confirmed to be valid and reliable and cannot be used for compliance reporting.	
36.8: 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	For this 21st Period review, based on review of a Process Document entitled Identification and Monitoring of Complex Behavioral, Health and Adaptive Support Needs, last updated 8/25/22, DBHDS had made progress toward	At the time of the 19th Period review, DBHDS did not submit any documentation to show it complied with these requirements or had developed a plan to do so. 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 Visit Tool (i.e., used by Support Coordinators to document key facets of the face-to-face visits), to flesh out this plan. For this 21st Period review, based on review of a Process Document entitled Identification and Monitoring of Complex Behavioral, Health and Adaptive Support	19th Not Met **21st Not Met**

Compliance Indicator	Facts	Analysis	Conclusion
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.	developing the capacity to report this measure, but it had not yet been implemented.	Needs, last updated 8/25/22, DBHDS had made progress toward developing the capacity to report this measure, but it had not yet been implemented. The steps outlined in the document included the following: 1. The Office of EHA or the Waiver Access Management System (WaMS) Senior Data Analyst staff will pull a statistically stratified annual sample of individuals with SIS level 6 and 7 support needs for a review of the ISP (Parts I-V). The sample will be stratified across CSBs and ensure that the number of individuals reviewed per CSB reflects the number of individuals the CSB serves. 2. A Spreadsheet/tool (Complex Medical, Behavioral, and Adaptive Needs Tracker) will be updated for each current review period for OIH reviewers to utilize. 3. For the names of individuals in step 1 e, the Risk Awareness Tool, Crisis Risk Assessment Tool, and On-Site Visit Tool will be requested from each CSB (if not already uploaded into WaMS). 4. Once all related documents have been obtained, DBHDS reviewers commence review of ISPs and documentation. The following are reviewed for/against: 5. The ISP Shared Planning (Part III) and Plan for Supports (Part V) will be reviewed by the Office of Integrated Health (and the Office of Crisis Services for behavioral support needs) to confirm that outcomes, support activities, and support instructions exist for each identified need. 6. OSVT for each individual will be reviewed by the Office of Provider Development to confirm that needs are reviewed at least quarterly o Risks and complex support needs related to health and behavioral needs identified by the support team are 1) included in specific outcomes in the ISP, 2). addressed in the Plan for Supports as evidenced in the support activities and/or support instructions, and 3) monitored by the Support Coordinator. o ISP elements used on conducting the review include: 1) Are there current Medical conditions? 2) Are there current Health Protocols? 3) Is there a history of past medical conditions? 4) Is there a history of hospitalizations? 5) Is there a history of surgeries? 6) Is there a history of mental health conditions? 7) Is there a history of psychiatric hospitalizations?	

Compliance Indicator	Facts	Analysis	Conclusion
		8) Communicable diseases? 9) Serious illnesses and/or chronic conditions of parents, siblings, and/or significant others in the same household? 7. As a part of this review, the Risk Awareness Tool (RAT) Summary for each individual will be reviewed by the Office of Integrated Health to confirm it is consistent with the Essential Information (Part II) of the ISP. Additionally, the Crisis Risk Assessment Tool (CAT) will be reviewed in this manner. 8. During review of ISP and related documents, the DBHDS OIH Registered Nurse Care Consultant reviewers will utilize the Complex Medical, Behavioral, and Adaptive Needs Tracker to determine if identified needs are included in outcomes, addressed in the Plan for Supports, and overall monitored by the Support Coordinator. 9. Data will be aggregated to arrive at overall findings for each CSB. This information will be provided to the Office of Provider Development's Director and the chair of the Case Management Steering Committee. 10. The Case Management Steering Committee chair will provide results of findings to individual CSB leadership. If findings suggest the need for remediation, corrective action will be initiated and overseen by the CM Steering Committee. 11. Based on step 8 above, the Case Management Steering Committee chair (or designee) will outline the required corrective action steps that are needed with an objective metric (e.g., SMART objective), provide due date(s), and monitor any steps to completion for any CSB found to be deficient. This be completed via correspondence with the CSB and documented accordingly. 12. Regardless of whether corrective action is required, the CM Steering Committee chair (or designee) will provide aggregate results to the CSB's DD Director (or equivalent role within the CSB) as a means to reinforce the on target performance of the CSB/their staff. Once implemented, this methodology should be sufficient to achieving the aims of the CI.	

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
37.1: 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 36.4 above, DBHDS established performance measure indicators (PMIs) that are in alignment with the eight domains that are reviewed by the DBHDS Quality	At the time of the previous review, the *DBHDS Quality Management Plan SFY20,* with an effective date of 3/31/21, evidenced that DBHDS had established three Key Performance Areas (KPAs) that addressed the eight domains listed in V.D.3.a-h. For this 21st Period review, the DBHDS Quality Management Plan SFY 2021 evidenced that 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.	19th Met* **21st 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 36.1 above and CI38.1 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.	In addition, DBHDS quality committees and workgroups have established performance measure indicators (PMIs) that are in alignment with the eight domains, and monitored their implementation. However, 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 could not be used to confirm compliance. For this 21st period Review, as described in detail with regard to CI 36.1 and CI 36.4 above, DBHDS quality committees and workgroups have established performance measure indicators (PMIs) that are in alignment with the eight domains. CI 36.2, CI 36.4, CI 36.6 and CI 36.7 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 36.1 above and CI 38.1 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 often cannot be used to confirm compliance.	
37.2: The assigned committees or workgroups report to the	Based on four quarters of QIC minutes, from 9/27/21 through 6/27/22,	For the 19th Period Review, QIC minutes reviewed evidenced that the QIC workgroups and committees reported to the QIC on identified PMIs, outcomes, and quality initiatives. However, DBHDS had not consistently completed a review of PMIs least	19th Not Met **21st Met***

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.	the QIC workgroups reported to the QIC on identified PMIs, outcomes, and quality initiatives. The Office of DQV (EHA) also reviewed PMIs at least annually consistent with the processes outlined for V.D.2, including the identification of any threats to data validity and reliability, and the QIC reviewed this information However, as described with regard to 36.1, DBHDS had not yet completed for all of the data sets used in the PMIs, Process Documents and Attestations that met all the criteria of the Curative Action for Data Reliability and Validity.	annually and consistently with the processes outlined in the compliance indicators for V.D.2. (i.e., CI 36.1), 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. and 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 could not be used to confirm compliance. For this 21st Period Review, based on four quarters of QIC minutes, from 9/27/21 through 6/27/22, the QIC workgroups reported to the QIC on identified PMIs, outcomes, and quality initiatives. The Office of DQV also reviewed PMIs at least annually consistent with the processes outlined for V.D.2, including the identification of any threats to data validity and reliability, and the QIC reviewed this information. This was consistent with a thorough process described in a document entitled *PMI Development and Annual Review Process Final*, dated 2/10/22. However, as described with regard to 36.1, DBHDS had not yet completed for all of the data sets used in the PMIs, Process Documents and Attestations that met all the criteria of the Curative Action for Data Reliability and Validity.	
37.3 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	As required by CI 37.3,the *Quality Management Plan SFY 2021* dated 5/16/22, the KPA workgroup charters and DI 316 assigned the respective domains to	As described with regard to CI 37.1 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	19th Met **21st Met**

Compliance Indicator	Facts	Analysis	Conclusion
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.	each KPA. Each KPA had a current charter that reiterated these assignments. The most recent charters were dated 9/27/21.	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 9/27/21.	
37.4: 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.	The *DBHDS Quality Management Plan SFY 2021* 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. The DBHDS Division of the Chief Clinical Officer also promulgated a	As reported at the time of the 19h Period review, the DBHDS *Quality Management Plan SFY 2020* detailed the quality committees and workgroups and reflected compliance. For this review, *Quality Management Plan SFY 2021,* dated 5/16/21, described the quality workgroups and committees (i.e., the RMRC, the MRC, the CMSC and the KPA Workgroups, including the Health, Safety, and Wellbeing, Community Integration and Inclusion and Provider Capacity and Competency, in essentially the same manner as previously and were in sustained compliance. The *Quality Management Plan SFY 2021* also continued to reference 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.	19th Met **21st Met**

Compliance Indicator	Facts	Analysis	Conclusion
	document entitled *Quality Committees Policy & Procedure,* dated 2/9/22, that memorialized expectations for the QIC and its associated subcommittees and workgroups.	The DBHDS Division of the Chief Clinical Officer also promulgated a document entitled *Quality Committees Policy & Procedure,* dated 2/9/22, that memorialized expectations for the QIC and its associated subcommittees and workgroups.	
37.5: 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	As detailed in the chart for CI 36.4, 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., define measures and the methodology for collecting data), as described with regard to CI 31.6 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	As detailed in the chart for CI 36.4 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 24 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). For sub-indicator d), as described with regard to CI 36.1 above, DBHDS achieved considerable progress in fully defining the methodology for collecting data for all PMIs. However, based on the findings for CI 36.1 and CI 38.1, for many of the applicable data sets, DBHDS had not yet determined they produced valid and reliable data, so the data cannot be used to support compliance findings.	19th Not Met **21st Met ***

Compliance Indicator	Facts	Analysis	Conclusion
	collecting data for all PMIs and the continuing deficiencies in the data source systems, as described for CI 36.1 and CI 38.1, the data reviewed cannot be confirmed to be valid and reliable and cannot be used to confirm compliance.		
37.6: 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.	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 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	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 below (i.e., for CI 37.9, 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. Based on review of minutes and surveillance data reporting provided for review (*SFY23 KPA Workgroups Schedule with Surveillance Data Requirements July 2022),* DBHDS workgroups and committees had a process in place to review the data on at least a semiannual basis and used the data to consider establishment of PMIs and/or quality improvement initiatives. 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 36.1 above and CI 38.1 below, the data reviewed cannot be confirmed to be valid and reliable and cannot be used for compliance reporting.	19th Not Met **21st Met***

Compliance Indicator	Facts	Analysis	Conclusion
	source systems, as described for CI 36.1 and CI 38.1, the data reviewed cannot be confirmed to be valid and reliable and cannot be used to confirm compliance. 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 36.1 above and CI 38.1 below, the data reviewed cannot be confirmed to be valid and reliable and cannot be used for compliance reporting.		
37.7: 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 36.1) and V.D.2 indicator 5 (i.e., CI 36.5) 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 be used for compliance reporting until they have	V.D.2 indicator 1 (i.e., CI 36.1) 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 36.5) requires that each KPA PMI describes key elements needed to ensure the data collection methodology produces valid and reliable data (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	19th Not Met **21st Not Met**

Compliance Indicator	Facts	Analysis	Conclusion
	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. The Office of DQV (EHA) had completed an assessment of the threats to data reliability and validity for each PMI. However, as part of the Curative Action for Data Validity and Reliability, the Parties had agreed that the assessment of data reliability and validity of the data sets for the PMIs described above in V.D.2, indicators 1 and 5 required a Process Document and Attestation. As described with regard to CI 36.1 above, for many of the applicable data sets, DBHDS had not yet determined they produced valid and reliable data, so the data	the numerator and denominator for calculation. For this 21st period review, it was positive that the Office of DQV (EHA) had completed an assessment of the threats to data reliability and validity for each PMI. However, as part of the Curative Action for Data Validity and Reliability, the Parties had agreed that the assessment of data reliability and validity of the data sets for the PMIs described above in V.D.2, indicators 1 and 5 required a Process Document and Attestation. As described with regard to CI 36.1 above, for many of the applicable data sets, DBHDS had not yet determined they produced valid and reliable data, so the data cannot be used to support compliance findings.	

Compliance Indicator	Facts	Analysis	Conclusion
	cannot be used to support compliance findings.		
37.8: The Quality Management Annual Report will describe the accomplishments and barriers for each KPA.	DBHDS issued a *Quality Management Annual Report State Fiscal Year 2021*, dated 5/16/22 that described the accomplishments and barriers for each KPA.	At the time of the previous studied, DBHDS had issued a *Quality Management Plan: Annual Report and Evaluation State Fiscal Year* for SFY 2019 and SFY 2020. For this review, the current version of the *Quality Management Annual Report State Fiscal Year 2021* was dated 5/16/22. It described the accomplishments and barriers for each KPA. As reported previously, it was positive to see that DBHDS staff had continued to adhere to a timeframe for production and distribution of the Report to approximately nine months after the period from approximately 12 months for the previous Report. However, they still needed to consider moving the timeframe for report production further forward, such that stakeholders received more recent information. In interview, DBHDS staff reported they were planning to implement changes to the timeline to attempt to provide this currency.	19th Met **21st Met**
37.9: 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	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 37.9.	As reported at the time of the previous review and as evidenced in the document entitled *SFY23 KPA Workgroups Schedule with Surveillance Data Requirements July 2022,* the HSWB KPA workgroup again finalized surveillance data related "safety and freedom from harm." These addressed all of the minimum criteria for CI 37.9, including a. Neglect and abuse; b. Injuries; c. Use of seclusion or restraints; d. Effectiveness of corrective action; e. Licensing violations and f. Deaths.	19th Met **21st 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	The HSWB KPA workgroup and RMRC developed and initiated performance measures for "safety and freedom from harm."	As referenced in the corresponding chart for CI 36.1above, 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	19th Met* **21st Met ***

Compliance Indicator	Facts	Analysis	Conclusion
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)	Each included a set target, or goal. 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 described for CI 36.1 and CI 38.1, DBHDS 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 36.1 and CI 38.1, for many of the applicable data sets, DBHDS had not yet determined they produced valid and reliable data, so the data cannot be used to support compliance findings.	

Compliance Indicator	Facts	Analysis	Conclusion
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."	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.	As reported at the time of the previous review and as evidenced in the document entitled *SFY23 KPA Workgroups Schedule with Surveillance Data Requirements July 2022,* the HSWB KPA workgroup again finalized surveillance data to be collected related "Physical, mental, and behavioral health and well-being," including: a. Access to medical care and b. timeliness and adequacy of interventions.	19th Met **21st 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 (ECM); National Core Indicators – (i.e., Health, Welfare and Rights); Individual and Provider Quality Service Reviews (QSRs); QMRs	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 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.	As referenced in the corresponding chart for CI 36.1 above, the HSWB KPA, workgroup, 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, or CMSC to monitor each performance measure. In addition, based on a review of meeting minutes DBHDS submitted, the HSWB KPA, and CMSC respectively monitored each of the assigned performance measures However, based on the findings for CI 36.1 and CI 38.1, for many of the applicable data sets, DBHDS had not yet determined they produced valid and reliable data, so the data cannot be used to support compliance findings.	19th Met* **21st Met ***

Compliance Indicator	Facts	Analysis	Conclusion
	Based on the findings described for CI 36.1 and CI 38.1, DBHDS 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.		
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	The HSWB KPA workgroup proposed surveillance data to be collected for ""avoiding crises." These addressed all of the minimum criteria for CI 37.13	As reported at the time of the previous review and as evidenced in the document entitled *SFY23 KPA Workgroups Schedule with Surveillance Data Requirements July 2022,* the HSWB KPA workgroup again finalized surveillance data to be collected for 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	19th Met **21st Met**
37.14: The Health, Safety and Well Being KPA workgroup will develop, initiate, and monitor performance measures	The HSWB KPA workgroup developed one performance measure for "avoiding crises."	As referenced in the chart for CI 36.1 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.	19th Met* **21st Met ***

Compliance Indicator	Facts	Analysis	Conclusion
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	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 monitored the performance measures. Based on the findings described for CI 36.1 and CI 38.1, DBHDS 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 36.1 and CI 38.1, for many of the applicable data sets, DBHDS had not yet determined they produced valid and reliable data, so the data cannot be used to support compliance findings.	
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,	The CII KPA workgroup proposed surveillance data to be collected for "stability." These addressed all of the minimum criteria for CI 37.15	As reported at the time of the previous review and as evidenced in the document entitled *SFY23 KPA Workgroups Schedule with Surveillance Data Requirements July 2022,* the CII KPA workgroup again finalized surveillance data to be collected related to "stability," including data related to living arrangement, providers, and participation in chosen work or day programs	19th Met **21st Met**

Compliance Indicator	Facts	Analysis	Conclusion
providers, and participation in chosen work or day programs.			
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	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 submitted, the CII KPA monitored each of the assigned performance measures. Based on the findings described for CI 36.1 and CI 38.1, DBHDS 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.	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 for CI 36.1 and CI 38.1, for many of the applicable data sets, DBHDS had not yet determined they produced valid and reliable data, so the data cannot be used to support compliance findings.	19th Met* **21st Met ***

Compliance Indicator	Facts	Analysis	Conclusion
37.17: The Community Inclusion/Integrated Settings KPA workgroup will finalize surveillance data to be collected for "Choice and self-determination."	The CII KPA workgroup proposed and finalized surveillance data to be collected for "choice and self-determination."	As reported at the time of the previous review and as evidenced in the document entitled *SFY23 KPA Workgroups Schedule with Surveillance Data Requirements July 2022,* the CII KPA workgroup proposed surveillance data to be collected for "choice and self-determination."	19th Not Met **21st 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	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 described for CI 36.1 and CI 38.1, DBHDS had not yet determined that the	As referenced in the corresponding chart for CI 36.1 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 36.1 and CI 38.1, for many of the applicable data sets, DBHDS had not yet determined they produced valid and reliable data, so the data cannot be used to support compliance findings.	19th Met* **21st Met***

Compliance Indicator	Facts	Analysis	Conclusion
	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.		
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.	The CII KPA workgroup proposed surveillance data to be collected for "community inclusion." These addressed all of the minimum criteria for CI 37.19	As reported at the time of the previous review and as evidenced in the document entitled *SFY23 KPA Workgroups Schedule with Surveillance Data Requirements July 2022,* the CII KPA workgroup again 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.	19th Met **21st 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;	The CII KPA workgroup and CMSC developed and initiated performance measures for "community inclusion." Each included a set target, or goal. DBHDS assigned the CII KPA workgroup and CMSC to monitor each performance measure.	As referenced in the corresponding chart for CI 36.1 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 However, based on the findings for CI 36.1 and CI 38.1, for many of the applicable data sets, DBHDS had not yet determined they produced valid and reliable data, so the data cannot be used to support compliance findings.	19th Met* **21st Met ***

Compliance Indicator	Facts	Analysis	Conclusion
QSRs; Housing; Regional Support Teams; Home and Community-Based Settings; NCI – (i.e., Individual Outcomes); WaMS	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 described for CI 36.1 and CI 38.1, DBHDS 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.		

Compliance Indicator	Facts	Analysis	Conclusion
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	The PCC KPA finalized surveillance data to be collected for "community inclusion." These addressed all of the minimum criteria for CI 37.21	As reported at the time of the previous review and as evidenced in the document entitled SFY23 KPA Workgroups Schedule with Surveillance Data Requirements July 2022, the PCC KPA workgroup again 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.	19th Met **21st 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	The PCC KPA workgroup and CMSC developed and initiated performance measures for "choice and self-determination." Each included a set target, or goal.	As referenced in the corresponding chart for CI 36.1 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 36.1 and CI 38.1, for many of the applicable data sets, DBHDS had not yet determined they produced valid and reliable data, so	19th Met* **21st Met ***

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 described for CI 36.1 and CI 38.1, DBHDS 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.	the data cannot be used to support compliance findings.	
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.	The PCC KPA finalized surveillance data to be collected for "Provide capacity." These addressed all of the minimum criteria for CI 37.2.	As reported at the time of the previous review and as evidenced in the document entitled SFY23 KPA Workgroups Schedule with Surveillance Data Requirements July 2022,, the Provider Competency and Capacity KPA workgroup again 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.	19th Met **21st Met**

Compliance Indicator	Facts	Analysis	Conclusion
Demonstration of competency in core competencies c. Demonstration of competency in elements of service for the individuals they serve.			
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. Based on the findings described for CI 36.1 and CI 38.1, DBHDS 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.	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 36.1 and CI 38.1, for many of the applicable data sets, DBHDS had not yet determined they produced valid and reliable data, so the data cannot be used to support compliance findings.	19th Met* **21st 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
38.1: 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	For this 21st Period review, DBHDS continued to collect data from each of these sources or, in some instances, their replacements (i.e., CONNECT). However, DBHDS had not analyzed serious incident or NCI data during this past year. The *Data Quality Monitoring Plan Source System Annual Update,* dated June 2022, outlined some steps taken to improve data quality in nine of the previously studied source systems, DBHDS did not assert that any of the source systems produced valid and reliable data. The Office of DQV (EHA) produced a document entitled *DBHDS Response to DQMP Recommendations*,	The single compliance indicator for this provision requires the Commonwealth to collect and analyze data from 13 source systems, at a minimum. Previous studies review examined the progress DBHDS had made in the areas of collecting and analyzing data from a set of prescribed sources. For this 21st Period review, DBHDS continued to collect data from each of these sources or, in some instances, their replacements (i.e., CONNECT). However, DBHDS had not analyzed serious incident or NCI data during this past year. In addition, based on its own internal self-assessments by the Office of DQV (EHA), questions with regard to the reliability of the data remained. Based on the documentation provided for this 21st Period review, as described with regard to CI 36.1 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 2022, outlined some steps taken to improve data quality in nine of the previously studied source systems, DBHDS did not assert that any of the source systems produced valid and reliable data. In response to a request from DBHDS leadership, the Office of DQV (EHA), produced a document entitled *DBHDS Response to DQMP Recommendations*, dated 8/26/22. This chart provided an overview of progress for recommendations made at the time of the original source system assessments. In summary, in addition to noting progress, it identified pending replacements, integrations and needed modifications for most of the data source systems. REACH is only source system for which the chart indicates that all identified recommendations have been addressed.	19th Not Met **21st 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	dated 8/26/22. It identified pending replacements, integrations and needed modifications for most of the data source systems. REACH is only source system for which the chart indicates that all identified recommendations have been addressed.		

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
39.1: 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."	The RQC charter, updated as of 9/27/21, 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 (i.e., *Master RQC Attendance FY22 and FY23*), each RQC met these criteria.	As described below with regard to CI 40.1, the RQC charter, updated as of September 2021, 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 (i.e., *Master RQC Attendance FY22 and FY23*), the RQCs typically met these criteria, although two reported difficulties services to recruiting and retaining individual receiving services to serve in these roles.	19th Met **21st Met**
39.2: 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 on 9/27/21 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	The Regional Quality Council Charter was revised and re-published on 9/27/21. As reported at the time of the 19th 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)	19th Met **21st Met**

Compliance Indicator	Facts	Analysis	Conclusion
	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 *Master RQC Roster FY2022* provided showed that DBHDS oriented at least 86% of RQC members.	• The provision of orientation In addition, for this review, DBHDS provided documentation to show it continued to provide 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. On 8/18/22, 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 *Regional Quality Councils Orientation And Training Practices*, effective 12/17/21, the completion of orientation was a requirement for all RQC members and alternates, consistent with the RQC Charter and the Office of Community Quality Improvement (OCQI) tracked completion for all members in the *Master RQC Roster FY2022*. The Roster provided for review indicated that, of the non-DBHDS membership, 61 of 70 (87%) had completed orientation.	
39.3 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 19th 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	19th Met **21st Met**

Compliance Indicator	Facts	Analysis	Conclusion
		remotely. According to the RQC Orientation referenced above with regard to CI 39.2, 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.	
39.4: 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).	DBHDS staff members continued to organize the agenda and the presentation of relevant data reports for review by the RQC members. The documentation for the four quarters for SFY 22 and for the first quarter of SFY 23. The minutes reflected significant improvement over previous periods, 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 consistently showed the RQCs were provided with comparisons of current data with that from previous quarters. However, based on the findings for CI 36.1 and CI 38.1, for many of the applicable data sets, DBHDS had not yet determined they produced valid and reliable data, so the data cannot be	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 presentation of relevant data reports for review by the RQC members. However, the preparation of data reports and presentation of data continued to be an evolving process with ongoing focused improvement efforts to increase the accuracy and validity of the data being presented. As reported at the time of the 19th Period, for this 21st Period 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 22 and for the first quarter of SFY 23. The documentation showed that DBHDS continued to demonstrate significant improvement over previous periods, 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 consistently showed the RQCs were provided with comparisons of current data with that from previous quarters. This allowed the RQC members to easily visualize trends over time and, as a result, formulate questions and requests for additional information. However, based on the findings for CI 36.1 and CI 38.1, for many of the applicable data sets, DBHDS had not yet determined they produced valid and reliable data, so the data cannot be used to support compliance findings.	19th Not Met **21st Met***

Compliance Indicator	Facts	Analysis	Conclusion
	used to support compliance findings.		
39.5: 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.	Based on the minutes for each RQC for the first through fourth quarters of SFY 2022, the study found continued improvement throughout. In addition to sustaining previous performance as described in the preceding paragraph, the data presentations often provided data in a manner that facilitated the ability of the RQC members to visualize possible trends. However, based on the findings for CI 36.1 and CI 38.1, for many of the applicable data sets, DBHDS had not yet determined they produced valid and reliable data, so the data cannot be used to support compliance findings.	At the time of the 19th Period review, the study found that 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. While the minutes reflected discussion of possible trends and requests for additional data that might inform quality improvement initiatives, 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. For this 21st Period, based on the minutes for each RQC for the first through fourth quarters of SFY 2022, the study found continued improvement throughout. In addition to sustaining previous performance as described in the preceding paragraph, the data presentations often provided data in a manner that facilitated the ability of the RQC members to visualize possible trends. However, based on the findings for CI 36.1 and CI 38.1, for many of the applicable data sets, DBHDS had not yet determined they produced valid and reliable data, so the data cannot be used to support compliance findings. .	19th Not Met **21st Met***

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.			
40.1: 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.	Based on documentation submitted (i.e., (i.e., *Master RQC Attendance FY22 and FY23*), 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 previous two reviews, this 21st Period review found 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 was updated on 9/27/21. It 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 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	19th Met **21st Met**

		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 FY22 and FY23*), each of the five RQCs achieved a quorum for all four quarters during SFY22, 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.). As reported previously, the *Master RQC Attendance FY2022* 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, as previously reported, while most RQCs had an individual receiving services as a member, consistent participation for that stakeholder group remained sporadic.	
40.2: 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.	As of 6/27/22, all five RQCs had recommended and implemented a QII for this review period. As described with regard to CI 39.4 and CI 39.5 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.	At the time of the 19th 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 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 RQCs had sustained the progress reported at the time of the previous review, and continued to improve, 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. For this 21st Period review, based on review of RQC and QIC minutes, as well as other QII documentation, the following describes the active QIIs as well as those recommended to the QIC on 6/27/22: • **Region 1 RQC:** By June 2023, increase the use of Electronic Home Based Services in Region 1 by 80 percent (which is 10 individuals) to 23 individuals, , which will result in an increase in the	19th Met* **21st Met***

	However, based on interview with the Office of EHA staff, they had not consistently provided assistance to the RQCs with regard to identification of possible threats to the reliability and validity for all QIIs. In addition, the QIIs reviewed often relied on existing data sets, but most did not have both a Process Document and a Data Set Attestation. Based on the findings described for CI 36.1 and CI 38.1, DBHDS 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.	number of people who live more independently. The baseline was 13 individuals as stated in the Provider Development Report in May of 2021. Status: Approved • **Region 2 RQC:** o By June 2023, increase the percentage of integrated community involvement (ICI) outcomes found in ISPs for individuals receiving case management services in Region 2 from a baseline of 56% to 86%. Status: Approved o By June 2022, prevent the rate of falls from returning to pre-COVID levels and "Maintain the Gain". (For the 6 months pre-COVID (10/1/19-3/31/20) the rate of falls in Region 2 was 67.76 per 1,000 Waiver population and since the beginning of the COVID-19 crisis, it has dropped to 31.78 from 4/1/20-12/31/2020.) Status: Continued • **Region 3 RQC**: By 6/25/2023, improve the rate of meeting DSP Competency requirement measures for Service Providers including CSBs to 86%. Status: Deferred because of concerns with the validity of the DMAS data that would be used. In response, RQC 3 indicated its plan to look for new QII opportunities and to submit a new QII for SFY 2024 implementation. • **Region 4 RQC**: by June 2023, to reduce the serious incident rate of UTIs in the I/DD Waiver population in Region 4 by 20% to 17.2 per 1000 I/DD individuals. Status: Deferred because of the current delay in the receipt of the data needed to implement the QII within the required 90 day implementation window. RQC 4 stated its intent to continue its work on the related driver diagram and RCA already begun, await the availability of the necessary data, and then resubmit the QII for QIC approval. • **Region 5 RQC (with RMRC):** o By June 2023, improve compliance with regulation 520.D for licensed DD providers in Region 5 to 86%. The baseline was 79% during CY2021.	

		Status: Approved o 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. Status: Continued However, based on interview with DQV (EHA) staff, they had not consistently provided assistance to the RQCs with regard to identification of possible threats to the reliability and validity for all QIIs. In addition, the QIIs reviewed often relied on existing data sets, but most did not have both a Process Document and a Data Set Attestation. Going forward, DBHDS staff will need to ensure that they consider the reliability and validity of data sets they use for QII projects, just as they do for other quality improvement efforts.	
40.3: 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 and 19th Period reviews, the respective studies 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 21st Period as well. As also described previous reviews, 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 continued to be noted in the minutes.	19th Met **21st Met**
40.4: 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	The RQC minutes 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 the	At the time of the 17th and 19th Period reviews, the respective studies found that minutes of each of the applicable meetings reflected compliance with these requirements. 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 the template. For this 21st Period review, the RQC minutes again showed sustained compliance.	19th Met **21st Met**

DBHDS, or c) determines that no action will be taken in that area.	template.		
40.5: For each quality improvement initiative recommended by the RQC, at least one measurable outcome will be proposed by the RQC.	Each QII was sufficiently measurable. When QIIs used a DBHDS data source system with identified deficiencies, they did not have consistently have a compliant Process Documents/Attestations showing how the data source could produce data sets with reliable and valid data for the specific purpose of the QII. For example, as described with regard to CI 36.1 above, the PMI referenced in the *Region 2 QII ICI Toolkit* did not yet have both a current and compliant Process Document and Attestation.	For the 19th Period, the study found that, for each quality improvement initiative recommended by the RQC, at least one outcome was proposed by the RQC; however, while the QII outcomes had some level of measurability, none were sufficiently measurable based on the information provided for review. The study recommended that, 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 would not be sufficiently measurable. DBHDS has 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, during previous reviews, 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." For this 21st Period review, it was positive to see the RQCs were also using QII Toolkits to develop their proposed QIIs. As reported at the time of the 20th Period review, the guidance from the *QII Toolkit Template FY22*, dated 1/10/22, appeared to address the key components of measurability. For the approved and active QIIs, the AIM statements and the QII Toolkits were helpful in understanding the extent to which the standards for measurability were met and where there continued to be concerns. For example, QII Toolkits often defined important terms. As an illustration of how this helped to demonstrate measurability, one of the Region 2 QII goals (i.e., to increase the percentage of integrated community involvement (ICI) outcomes found in ISPs for individuals receiving case management services in Region 2) did not, in its face, define the ICI outcomes; however, the QII Toolkit clarified that specifically, these were the outcomes for community inclusion or community integration in the Integrated Community Involvement area of the ISP with a ratio of no more that 1 staff person to 3 individuals.	19th Not Met **21st Met***

		In addition, the QII Toolkits consistently provided a numerator and denominator, which was positive. For example, on its face, the Region 1 goal appeared to have multiple variables (i..e, the increase in the number of people receiving EHBS and the number of people living more independently). The Toolkit made clear that the numerator and denominator focused only on the former variable as the QII measure. This was helpful, but, going forward, RQCs should be cautious about making sure the stated goal is clearly stated. When QIIs used a DBHDS data source system with identified deficiencies, they did not have consistently have a compliant Process Documents/Attestations showing how the data source could produce data sets with reliable and valid data for the specific purpose of the QII. For example, as described with regard to CI 36.1 above, the PMI referenced in the Region 2 QII ICI Toolkit did not yet have both a current and compliant Process Document and Attestation.	
40.6: 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 and materials , 100% of recommendations agreed upon by the RQCs are presented to the DBHDS QIC. This study examined the SFY 22 fourth quarter minutes for each RQC to identify any recommendations for the QIC, as well as the QIC minutes for June 27, 2022 to determine if the recommendations were presented. The *Q4 Regional Quality Councils Report to the QIC* documented one recommendation, from RQC 1, for the formation of a committee, inclusive of provider representation, to evaluate the impact of staffing shortages on providers' ability to address provider capacity/competency issues and report results to the QIC. This appeared to accurately reflect the relevant RQC recommendations for the QIC.	19th Met **21st Met**
40.7: 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	The QIC had reviewed at least one QII recommended by each RQC. Based on review of the fourth quarter Regional Quality Councils Report to the QIC, dated 6/27/22, all five RQCs reported on the status of their existing, abandoned and/or proposed QIIs, as well as on any RQC recommendations to the QIC.	For this review, and based on the QIC minutes DBHDS provided for review, the QIC had reviewed at least one QII recommended by each RQC, as described above with regard to CI 40.2. Based on review of the fourth quarter Regional Quality Councils Report to the QIC, dated 6/27/22, all five RQCs reported on the status of their existing, abandoned and/or proposed QIIs. As reported with regard to CI 40.2, when the QIC declined to support a recommended QII, the Senior Director of Clinical Quality Management sent the respective RQC a written response to document the reason for the determination. This was in addition to the discussion documented during the QIC meetings. Also based on review of the fourth quarter Regional Quality Councils Report to the QIC, all five RQCs reported on their monitoring of statewide quality improvement initiatives and their analysis of statewide and regional impact.	19th Not Met **21st Met**

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.	When the QIC declined to support a recommended QII, the Senior Director of Clinical Quality Management sent the respective RQC a written response to document the reason for the determination Based on review of the fourth quarter Regional Quality Councils Report to the QIC, all five RQCs reported on their monitoring of statewide quality improvement initiatives and their analysis of statewide and regional impact	The draft QIC minutes for 6/7/22 and the corresponding Q*4 Regional Quality Councils Report to the QIC* for the same date, show that each RQC reported any recommendations for the QIC regarding systemic improvement. The Q*4 Regional Quality Councils Report to the QIC* documented one recommendation. RQC 1 recommended that the formation of a committee, inclusive of provider representation, to evaluate the impact of staffing shortages on providers' ability to address provider capacity/competency issues and report results to the QIC. While the draft QIC minutes did not reflect that the QIC responded at that time, this CI requires only that the QIC respond at least once each year.	

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
41.1: 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.	For this review, DBHDS provided a *Provider Data Summary Semi-Annual Report State Fiscal Year 2021.* It was dated 5/1/22 (final 7/122). The report provided data reports, including 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, on eleven relevant measures. However, based on the findings for CI 36.1 and CI 38.1, for many of the applicable data sets, DBHDS had not yet determined they produced valid and reliable data, so the data cannot be used to support compliance findings.	At the time of the 19th Period Review, 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 41.1. For this review, DBHDS provided a *Provider Data Summary Semi-Annual Report State Fiscal Year 2021.* It was dated 5/1/22 (final 7/122). The report provided data reports, including 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, on the following measures: • Data continues to indicate an annual 2% increase in the overall DD waiver population receiving services in the most integrated settings • 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 • The Data Summary indicates an increase in services available by locality over time • 95% of provider agency staff meet provider orientation training requirements • 95% of provider agency direct support professionals (DSPs) meet competency training • Requirements • At least 95% of people receiving services/authorized representatives participate in the development of their own service plan • At least 75% of people with a job in the community chose or had some input in choosing their job	19th Not Met **21st Met***

Compliance Indicator	Facts	Analysis	Conclusion
		• At least 86% of people receiving services in residential services/their authorized representatives choose or help decide their daily schedule • 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 • At least 50% of people who do not live in the family home/their authorized representatives chose or had some input in choosing their housemates However, based on the findings for CI 36.1 and CI 38.1, for many of the applicable data sets, DBHDS had not yet determined they produced valid and reliable data, so the data cannot be used to support compliance findings. Other Independent Reviewer studies determined that the summary data related to DSP competency based training could not be verified.	
41.2: 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	For this review, DBHDS provided a *Provider Data Summary Semi-Annual Report State Fiscal Year 2021.* It was dated 5/1/22 (final 7/122). The report provided the demographics required by this CI. However, based on the findings for CI 36.1 and CI 38.1, for many of the applicable data sets, DBHDS had not yet determined they produced valid and reliable data, so the data cannot be used to support compliance findings.	For this review, DBHDS provided a *Provider Data Summary Semi-Annual Report State Fiscal Year 2021.* It was dated 5/1/22 (final 7/122). The report provided the demographics required by this CI. However, based on the findings for CI 36.1 and CI 38.1, for many of the applicable data sets, DBHDS had not yet determined they produced valid and reliable data, so the data cannot be used to support compliance findings.	19th Not Met **21st Met***

Compliance Indicator	Facts	Analysis	Conclusion
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.			
41.3: 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	For this review, DBHDS provided a *Provider Data Summary Semi-Annual Report State Fiscal Year 2021.* It was dated 5/1/22 (final 7/122). The report provided the demographics required by this CI.	For this review, DBHDS provided a *Provider Data Summary Semi-Annual Report State Fiscal Year 2021.* It was dated 5/1/22 (final 7/122). The report provided the demographics required by this CI. However, based on the findings for CI 36.1 and CI 38.1, for many of the applicable data sets, DBHDS had not yet determined they produced valid and reliable data, so the data cannot be used to support compliance findings.	19th Not Met **21st Met***

Compliance Indicator	Facts	Analysis	Conclusion
housing options created			
41.4: 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	DBHDS last issued an *Annual Quality Management Report and Evaluation* on 5/16/22. The previous version was issued on 3/31/21 It included information for all the topics defined in the CI 43.4. However, based on the findings for CI 36.1 and CI 38.1, for many of the applicable data sets, DBHDS had not yet determined they produced valid and reliable data, so the data cannot be used to support compliance findings. .	Previous review, the data and information were anywhere from 9-12 months 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 21st Period review, DBHDS last issued an updated version of the document, dated 5/16/22 (i.e., *Developmental Disabilities Quality Management Plan State Fiscal Year* 2021). 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 2021* covered a period between 7/1/20 -6/30/21. These data were still approximately 11 months old and again not particularly useful in providing the public with a status report or for actionable quality improvement. However, as described with regard to CI 37.8 above, in interview, DBHDS staff reported they were planning to implement changes to the timeline to attempt to provide this currency. However, based on the findings for CI 36.1 and CI 38.1, for many of the applicable data sets, DBHDS had not yet determined they produced valid and reliable data, so the data cannot be used to support compliance findings. .	19th Not Met **21st Met***

Compliance Indicator	Facts	Analysis	Conclusion
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. Recommendations and strategies for related improvement			
41.5: Additional information, including areas	At the time of the 19th Period review, DBHDS	At the time of the 19th Period review, DBHDS submitted a document entitled *DOJ Settlement Agreement Library Protocol*, dated June 30, 2020. As described above	19th Not Met

Compliance Indicator	Facts	Analysis	Conclusion
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. Integrated Day Services Report k. DBHDS Annual Report l. National Core Indicators Annual Report and Bi-Annual National Report.	submitted a document entitled *DOJ Settlement Agreement Library Protocol*, dated June 30, 2020. As described above with regard to CI 41.1, 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 41.5 were not available or were outdated.	with regard to CI 41.1, the protocol described the requirements for maintaining and updating the Library site at http://dojsettlementagreement.virginia.gov/. The protocol indicated 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 stated 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 required an annual audit. However, at the time of the 19th Period review, in interview, the DBHDS Settlement Agreement Coordinator stated the audit process was behind schedule. For this 21st Period review, DBHDS did not submit any additional documentation or indicate whether the *DOJ Settlement Agreement Library Protocol*, dated June 30, 2020 remained current. As reported at the time of the 19th Period review, documentation available the Library site and/or DBHDS website during this 21st Period, many of the designated reports for CI 41.5 were still not available or were outdated on . the Library site. There was improvement noted with regard to availability on the DBHDS website, but some reports were still not found. For example, the website still had RST annual reports from 2020 and the Annual REACH report and Annual DBHDS Report could not be located It remained notable, as well, that during this and previous study periods, the consultant often found it 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 recommended for that CI, DBHDS should conduct an analysis of its websites and make modifications to simplify the process.	**21st Not Met**

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
42.1: 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 and reports on statewide	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.	As reported previously, for this review, DBHDS had final regulations at *12VAC35-105-620*, entitled "Monitoring and evaluating service quality," to require licensed providers to develop and maintain quality improvement programs. 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 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*	19th Met **21st Met**

Compliance Indicator	Facts	Analysis	Conclusion
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.		*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.*	
42.2: 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.	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 11/28/20. These documents addressed the requirements consistent with regulations. DBHDS also provided an undated document entitled *V.E.1: Protocol for how the Office of Licensing* describing how it determines whether DBHDS needs to update guidance documents.	At the time of the 19th Period review, 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.*" Based on documentation provided for CI 32.1, these guidance documents remained current.	19th Met **21st Met**

Compliance Indicator	Facts	Analysis	Conclusion
		DBHDS did not have a policy, procedure or operational protocol to show how DBHDS staff would determine whether updates and/or revisions to this guidance were necessary. 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. For this 21st Period review, DBHDS provided an undated document entitled *V.E.1: Protocol for how the Office of Licensing* describing how it determines whether DBHDS needs to update guidance documents. The document indicates Office of Licensing guidance documents will be revised when any of the following criteria are met: • There are changes to applicable state or federal statutory law; • There are changes to the regulatory language under which the guidance was promulgated; • A formal determination is made, based on stakeholder feedback, that amendments are needed to provide greater clarity; • A formal determination is made, based on an analysis of regulatory citations, that amendments are needed to provide greater clarity to reduce regulatory citations; or • Changes to internal operating protocols prompt a change to the protocols outlined within the external guidance document. When determination is made that a change is needed, the document indicates the following will occur: • The Associate Director for Licensing, Regulatory Compliance, and Training will notify the Office of Regulatory Affairs (ORA) of the intent to revise guidance, so that the Unified Regulatory Plan can be updated. • The Associate Director for Licensing, Regulatory Compliance, and Training and/or the Legal Operations Manager will work alongside Office SMEs to draft any necessary changes. • Draft changes will be circulated amongst OL and agency leadership, as appropriate for approval.	

Compliance Indicator	Facts	Analysis	Conclusion
		• The draft changes will be submitted to the Office of Regulatory Affairs to post on the Virginia Regulatory TownHall website. • Once the draft guidance document is sent to the TownHall website, formal correspondence will be sent to all stakeholders through constant contact regarding the state date for the public comment period. • Following the 30-day public comment period, a determination will be made as to whether or not additional changes are needed based on stakeholder feedback. • If no additional changes are needed, communication will be sent to ORA that no changes are needed and the document shall be finalized. • If changes are needed, the Associate Director for Licensing, Regulatory Compliance, and Training and/or the Legal Operations Manager will work alongside Office SMEs to draft any additional changes and circulate for approval, as appropriate. Once the document is finalized, communication will be sent to ORA that no changes are needed and the document shall be finalized.	
42.3: 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.	Based on self-reported data, during 2021, only 83% of providers were compliant with 12 VAC 35-105-620. For the first six months of the 2022 calendar year, the aggregate percentage was 84%. While DBHDS provided a PMI, a Process Document and an attestation, these contained the following discrepancies that DBHDS staff must address to achieve compliance: • The calculation for the Denominator must be	For this 21st Period review, DBHDS provided the following data for review: • For the 2021 calendar year (i.e., 1/1/21 through 12/31/21), DBHDS provided a report that documented the percentage of providers that were assessed for 100% of the applicable quality improvement regulations at 83%. • For the first quarter of the 2022 calendar year (i.e., 1/1/22 through 3/3/1/22, DBHDS provided a report that documented the percentage of providers that were assessed for 100% of the quality improvement regulations at 79%. • For the second quarter of the 2022 calendar year (i.e., 4/1/22 through 6/30/22, DBHDS provided a report that documented the percentage of providers that were assessed for 100% of the quality improvement regulations at 86%. Based on these self-reported data, this CI was not met. For the 2021 calendar year , the percentage was 83%. For the first six months of the 2022 calendar year, the aggregate percentage was 84% .	19th Not Met **21st Not Met**

Compliance Indicator	Facts	Analysis	Conclusion
	more clearly and accurately defined, and the methodologies must clearly define the business rules and standards for conformance related to application of exclusionary criteria. • The PMI template updated on 8/19/22 and the Process Document, entitled *DOJ Process QI Requirements, Version 001* and dated 12/27/21 did not have the same calculation steps. It was not clear which were correct. • DBHDS provided an attestation, dated, 9/19/22. However, the applicable Process Document did not lay out the standards for potential exclusion of providers from the denominator or their consistent application. Therefore, the attestation did not reflect an adequate assessment of measure validity.	With regard to data reliability and validity, at the time of the 19th Period review, this study documented that in order to report the metric required by this CI, it would 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 needed to include how DBHDS will take this into account in calculating the denominator. Overall, the PMI lacked clarity about how DBHDS has chosen to address the denominator relevant to both this CI and CI 43.4 below. As written, the denominator had the potential to exclude some number of providers that did not have an assessment of review of their compliance with quality improvement regulations during their annual inspections. The Business Definitions & Processes section of the PMI addressed some, but not all, of those potential exclusions. While it was possible that the Office of Licensing has some other protocols staff took into account, they were not clearly represented in the PMI methodology. For this 21st Period review, DBHDS initially submitted a PMI template, last updated on 8/19/22, 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." This PMI methodology was intended to address CI 42.3 as well as 42.4 below. The PMI template stated the Denominator as "number of licensed DD providers, by service, that were assessed for quality improvement regulations during an annual unannounced inspection." However, similar to the findings of the 19th Period review, this did not explicitly address the requirements of CI 42.3. Upon discussion of this concern during interviews for this study, DBHDS staff drafted a revision of the calculations for CIs 42.3 and 42.4. It stated the denominator for CI 42.3 was "the total number of providers that had annual inspections during the reporting period." However, the Business Rules and Processes section stated that "DBHDS believes that using the number of provider/services that were inspected for compliance with QI regulations as the denominator provides a reasonable estimate of the	

Compliance Indicator	Facts	Analysis	Conclusion
		number of providers that should be compliant with this regulation." The Business Rules and Processes section went on from there to state that "(t)herefore, for purposes of this measure, DBHDS is operationalizing "providers" (to be used as the denominator) as the number of licensed services that had an inspection of any regulation during the reporting year." In context, it was not clear whether this meant any regulation or any quality improvement regulation. If the latter, it is circular logic to state that those who were inspected were those that should have been inspected, and this was insufficient to ensure the validity of this measure. If the former, it does not factor in the providers for whom DBHDS identified a need to exclude from the Denominator. In any event, the revised document did not provide the clarity required. Based on the wording of this CI and the potential for exclusion of some providers from the Denominator, DBHDS should consider whether the Denominator should be the number of licensed DD providers, by service, that had an annual unannounced inspection subject to an assessment for any or all quality improvement regulations. Both the PMI methodology and the associated Process Document should then spell out the specific standards for an annual unannounced inspection subject to an assessment for quality improvement regulations, including the acceptable exclusionary criteria and the standards Licensing Specialists must follow when applying them. While DBHDS provided a PMI, a Process Document and an attestation, these contained the following discrepancies that DBHDS staff must address to achieve compliance: • As described above, the calculation for the Denominator must be more clearly and accurately defined, and the methodologies must clearly define the business rules and standards for conformance related to application of exclusionary criteria. • The methodologies for obtaining and calculating the numerator and denominator must be consistent between the PMI and the Process Document. As provided for review for this 21st period, the PMI template updated on 8/19/22 and the Process Document, entitled DOJ Process QI Requirements, Version 001 and dated 12/27/21 did not have the same calculation steps. It was not clear which were correct.	

Compliance Indicator	Facts	Analysis	Conclusion
		• DBHDS provided an attestation, dated, 9/19/22. However, the applicable Process Document applied the logic that the Denominator included only those providers for whom Licensing reviewed at least one QI regulation and did not lay out the standards for exclusion and their consistent application. Therefore, the attestation did not reflect an adequate assessment of measure validity. In addition, as noted in the previous bullet, it was not clear if the calculation steps were accurate.	
42.4: 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.	Based on self-reported data, during 2021, only 52% of providers were compliant with 12 VAC 35-105-620. In the first two quarters of 2022, the percentage of compliant providers did not exceed 54%. DBHDS did not provide requested evidence to show that non-compliant providers implemented the required CAPs. A t the time of the 19th Period review, this study noted that the business rules and definitions of the PMI would not necessarily provide a valid denominator for this CI. As further described with regard to CI 42.3, for this 21st Period review, this continued to need	At the time of the 19th Period review, the Independent Reviewer found that, while it was useful to report compliance levels for each of the components of the licensing regulations (i.e., to allow DBHDS to focus systemic guidance and corrective action for quality improvement purposes), , to assess compliance with this CI, it would 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. Based on a Curative Action the Parties filed with the Court on 4/2/22, the Commonwealth agreed to calculate the measure by determining whether 86% of the providers were compliant with each of the 11 sub-regulations, and including an evaluation of whether the provider was implementing its QI plan. For this 21st Period review, DBHDS provided the following data for review: • For the 2021 calendar year (i.e., 1/1/21 through 12/31/21), DBHDS provided a report that documented the percentage of providers that were compliant with 100% of the quality improvement regulations at 52%. • For the first quarter of the 2022 calendar year (i.e., 1/1/22 through 3/3/1/22, DBHDS provided a report that documented the percentage of providers that were compliant with 100% of the quality improvement regulations at 52%. • For the second quarter of the 2022 calendar year (i.e., 4/1/22 through 6/30/22, DBHDS provided a report that documented the percentage of providers that were compliant with 100% of the quality improvement regulations at 54%.	19th Not Met **21st Not Met**

Compliance Indicator	Facts	Analysis	Conclusion
	resolution.	Based on these self-reported data, this CI is not met. In addition, DBHDS did not provide requested evidence to show that non-compliant providers implemented the required CAPs. With regard to data reliability and validity, at the time of the 19th Period review, this study noted that the business rules and definitions of the PMI would not necessarily provide a valid denominator for this CI. As further described with regard to CI 42.03, for this 21st Period review, this continued to need resolution.	
42.5: 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 *Departmental Instruction 316 (QM) 20, Quality Improvement, Quality Assurance, and Risk Management for Individuals with Developmental Disabilities* (DI 316), dated 4/7/21, which addressed all of addressed all of the requirements for CI 42.05. DBHDS did not provide any The document addressed all of the requirements for CI 42.5. In addition, DBHDS provided the following documentation to show Training Center 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;	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) and 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 the 19th Period review, DBHDS provided an updated DI 316, effective 04/7/21. The document addressed all of the requirements for CI 42.5, including previously noted deficiencies with regard to root cause analysis. However, at the time of the 19th Period review, DBHDS did not provide any 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-wide quality improvement initiatives; or to show that the Training Center monitored implementation and effectiveness of quality improvement initiatives. For this 21st Period review, DBHDS provided an updated DI 316, effective 04/7/21. The document addressed all of the requirements for CI 42.5. In addition, DBHDS provided the following documentation to show Training Center 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;	19th Not Met **21st Met**

Compliance Indicator	Facts	Analysis	Conclusion
	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: • *34.8_SEVTC_Annual 22 Summary* • *34.8_SEVTC_FY 23 RM QI initiatives* • *34.8_SEVTC_trigger threshold table FY23*	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: • *34.8_SEVTC_Annual 22 Summary* • *34.8_SEVTC_FY 23 RM QI initiatives* • *34.8_SEVTC_trigger threshold table FY23*	

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
43.1 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 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	The Parties agreed upon a Curative Action, filed with the Court on 11/9/21. The Curative Action required DBHDS to gather information from the Quality Services Review (QSR) process during Round 3, utilizing specific questions on the Person-Centered Review (PCR) Tool to be identified as provider reporting measures. DBHDS determined that instead of using questions from the PCR, it will use data from three PQR questions to evaluate the following provider reporting measure for promotion	At the time of the 19th Period review, DBHDS had not fully developed processes for provider measure reporting, but had developed measures based on data that DBHDS-licensed DD providers, including CSBs, were required to report to DBHDS on a regular basis. These six provider reporting measures identified each as assessing either a positive of negative aspect of health and safety and of community integration. The measures included both types (i.e., positive and negative aspects) of measures and were selected from relevant domains listed in Section V.D.3. The data for reporting these measures was 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 CHRIS-SIR, DBHDS informed providers of these requirements through regulations at *12VAC35-105-160*, but did not provide evidence to show how they informed providers with regard to the measures for which data were collected from WaMS. In addition, while 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, at the time of the 19th Period review, DBHDS did not obtain data with regard to these measures from providers' QI programs. DBHDS also did not report the data out in a manner that allowed providers to use them for their own quality improvement needs (i.e., the data reporting is not broken down by provider.) For this review, the Parties had agreed upon a Curative Action, filed with the Court on 11/9/21. The Curative Action required DBHDS to gather	19th Not Met **21st Not Met**

Compliance Indicator	Facts	Analysis	Conclusion
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.	of community integration. The Curative Action also required DBHDS to continue to o collect and report data for these 12 surveillance measures related to negative aspects of health and safety that come from provider critical incident reporting. For the measures for which data are collected through CHRIS-SIR, DBHDS informed providers of these requirements through regulations at 12VAC35-105-160. The Curative Action also states it will not be considered operational until DBHDS finds that the QSR data related to this data set for V.E.2 provides reliable and valid data for compliance reporting and the Independent Reviewer reviews and determines that DBHDS	information from the Quality Services Review (QSR) process during Round 3, utilizing specific questions on the Person-Centered Review (PCR) Tool to be identified as provider reporting measures. DBHDS determined that instead of using questions from the PCR, it will use data from three PQR questions to evaluate the following provider reporting measure for promotion of community integration: 86% of providers demonstrate a commitment to community inclusion by demonstrating actions that lead to participation in community integration activities. This measure defines the demonstration of commitment to community inclusion based on the extent to which providers demonstrate the following: a. N: The number of providers who promote meaningful work/ D: Number of providers reviewed b. N: The number of providers who promote individual participation in non-large group activities/D: Number of providers reviewed c. N: The number of providers who encourage participation in community outings with people other than those with whom they live/D: Number of providers reviewed Other specific requirements, and the current status of each, of the Curative Action are described below for this CI and for CI 43.2 below • *The QSR vendor will present individual data gathered from QSR process to providers and individual and aggregate data to DBHDS. As part of the QSR quality improvement process, providers will be expected to incorporate their individual results into their QI programs and track and address them as measurable goals and objectives*: Following Round 3, the QSR vendor presented data to providers and to DBHDS. • *DBHDS will track and address overall statewide results through its QI committees, and providers will be expected to track and address their individual results through their QI programs. DBHDS will report overall state-wide results to providers to assist them in setting goals for their programs:* Following Round 3, the QSR vendor presented data to providers and to DBHDS. • *To ensure reliability and validity, DBHDS will ensure that appropriate tools that specify the parameters for collecting this data are made available to providers.*	

Compliance Indicator	Facts	Analysis	Conclusion
	utilized a sufficient methodology to reach its findings. This has not yet occurred. The Curative Action requires that DBHDS must ensure that appropriate tools that specify the parameters for collecting this data are made available to providers (i.e., a function of notification to providers.) This was scheduled to begin after the conclusion of the 21st Period review and therefore cannot yet be evaluated for compliance. Based on interview, DBHDS is currently working on the appropriate tools that specify the parameters for collecting this data that have been made available to providers. Based on the evaluation of CI 36.1, DBHDs did not have a plan in place to evaluate the QSR as a data source system and had not otherwise	*Significant deviations between data collected through the QSR process and data collected by a provider will be reviewed, assessed corrected. The FY23 round of QSRs will begin approximately in October 2022, and this is when providers will begin to collect and report this data to DBHDS.* This was scheduled to begin after the conclusion of the 21st Period review and therefore cannot yet be evaluated for compliance. Based on interview, DBHDS is currently working on the appropriate tools that specify the parameters for collecting this data that have been made available to providers. • *Additionally, DBHDS will continue collecting the negative aspects of health and safety that come from provider critical incident reporting (provider risk measures). Documentation of the process for calculating and reporting these rates is described in the document "Risk Incident Monitoring Rates." Providers are required to report all serious incidents within 24 hours of identification. The RMRC developed 12 measures from the critical incidents reported by providers. These measures are closely tied with the risks that are reviewed with the Risk Awareness Tool (RAT), and report the incidence rate for the 12 conditions as a proportion of the number of individuals on the DD waivers. The 12 rates measured are: aspiration pneumonia, bowel obstruction, sepsis, decubitus ulcer, fall, dehydration, seizure, urinary tract infection, choking, self-injury, sexual assault, and suicide attempt. The "Surveillance Measures" report is reported quarterly to the RMRC. These measures were reported beginning in FY2021.* Based on the RMRC and QIC minutes reviewed, the RMRC continues to collect for these 12 surveillance measures related to negative aspects of health and safety, but because they are derived from provider critical incident reporting, the committee has not been able to review and analyze serious incident data for approximately one year. • *Information collected by DBHDS through the process laid out above will be selected from the following domains listed Section V.D.3: a. Safety and freedom from harm (e.g., neglect and abuse, use of seclusion or restraints); b. Physical, mental, and behavioral health and well being (e.g., access to medical care (including preventative care), timeliness and adequacy of interventions, particularly in response to changes in status); c. Avoiding crises (e.g., use of crisis services, admissions to emergency rooms or hospitals, admissions to Training Centers or other congregate settings, contact with criminal justice system); and f. Community inclusion (e.g., community activities,*	

Compliance Indicator	Facts	Analysis	Conclusion
	completed a Process Document or Attestation for the QSR-derived data. Also based on the facts described for CI 36.1, due to data quality concerns with regard to the data source systems for the measures derived from serious incident data (i.e., CHRIS-SIR and CONNECT), the data cannot be confirmed to be valid and reliable and cannot be used for compliance reporting.	*integrated work opportunities, integrated living options, educational opportunities, relationships with non-paid individuals).* • *This curative action will not be considered operational until DBHDS finds that the QSR data related to this data set for V.E.2 provides reliable and valid data for compliance reporting and the Independent Reviewer reviews and determines that DBHDS utilized a sufficient methodology to reach its findings:* This has not yet occurred. Based on the evaluation of CI 36.1, DBHDs did not have a plan in place to evaluate the QSR as a data source system and had not otherwise completed a Process Document or Attestation for the QSR-derived data. Also based on the facts described for CI 36.1, due to data quality concerns with regard to the data source systems for the measures derived from serious incident data (i.e., CHRIS-SIR and CONNECT), the data cannot be confirmed to be valid and reliable and cannot be used for compliance reporting.	
43.2: 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.	Per the Curative Action, the 12 surveillance measures related to negative aspects of health and safety will continue to be derived from provider critical incident reporting. Also, for the QSR-reported measure, per the Curative Action, DBHDS will require providers that are not participating in the QSR in a given year to still collect and report the data above to DBHDS,	Per the Curative Action, the 12 surveillance measures related to negative aspects of health and safety will continue to be derived from provider critical incident reporting. Of note, as described with regard to CI 36.1 and 43.1 above, DBHDS had not been able to review serious incident data for many months and were not able to attest to the validity and reliability of the data. For the community integration measure, the Curative Action states that "*All providers were reviewed during Round 3 QSR. Going forward, because a specific provider might only be included in the QSR review every two to three years, …DBHDS will require providers that are not participating in the QSR in a given year to still collect and report the data above to DBHDS, with the expectation that approximately 50% of all providers will collect and report this data each year.* DBHDS did not yet have protocols in place for ensuring this reporting or its measurement.	19th Not Met **21st Not Met**

Compliance Indicator	Facts	Analysis	Conclusion
	with the expectation that approximately 50% of all providers will collect and report this data each year. DBHDS did not yet have protocols in place for ensuring this reporting or its measurement. As described with regard to CI 36.1 above, DBHDS had not been able to review serious incident data for many months and were not able to attest to the validity and reliability of the data.		
43.3: 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	DBHDS did not provide evidence that the Office of DQV (EHA) had completed an analysis of the community integration measure derived from the QSR data. Based on the findings for CI 36.1, DBHDS did not provide a Process Document or Attestation to show the measure produced valid and reliable data, so the data	Beginning with measures active for SFY20 or after, the Office of EHA 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. However, DBHDS did not provide evidence that the Office of DQV (EHA) had completed an analysis of the community integration measure derived from the QSR data. In addition, based on the findings for CI 36.1, DBHDS did not provide a Process Document or Attestation to show the measure produced valid and reliable data, so the data cannot be used to support compliance findings.	19th Not Met **21st Not Met**

Compliance Indicator	Facts	Analysis	Conclusion
annually and update accordingly.	cannot be used to support compliance findings.		
43.4: 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.	For this review, per the applicable Curative Action described above, DBHDS had defined provider reporting measures in all required domains. For this review, though, as described with regard to CI 36.1 and elsewhere in this Provision, DBHDS had not been able to review or analyze serious incident data for approximately one year. This resulted in a finding of Not Met. .	For previous reviews, 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 For this review, per the applicable Curative Action described above, DBHDS had defined provider reporting measures in all required domains. For this review, though, as described with regard to CI 36.1 and elsewhere in this Provision, DBHDS had not been able to review or analyze serious incident data for approximately one year. This resulted in a finding of Not Met.	19th Not Met **21st Not Met**

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
44.1: 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	DBHDS provided the QSR PQR Tool, which included seven questions related to the provider's quality improvement program. Each question was accompanied by a column entitled *Evaluation Criteria* and another column with the heading *Reviewer Notes* that provided additional guidance The questions, evaluation criteria and additional guidelines overall did not provide a clear procedure for addressing each of the specific criteria defined in the CI as necessary to the assessment and determination of the adequacy of providers' quality improvement programs. Based on the findings from the 20th Period QSR report for CI 53.3, for	At the time of the 19th Period review, DBHDS did not provide documentation to show how they used QSR data to meet the requirements of that provision. For this 21st Period, DBHDS provided the QSR PQR Tool, which included seven questions related to the provider's quality improvement program. Each question was accompanied by a column entitled *Evaluation Criteria* and another column with the heading *Reviewer Notes* that provided additional guidance, as described further below. In summary, the questions, evaluation criteria and additional guidelines overall did not provide a clear procedure for addressing each of the specific criteria defined in the CI as necessary to the assessment and determination of the adequacy of providers' quality improvement programs. In addition, there were other factors negatively impacting the validity and reliability of the data collected in the QSR process. The following describes examples of concerns noted: • The evaluation criteria and reviewer notes sometimes seemed to conflict in a manner that could lead to considerable variation among reviewers. It was therefore not clear that the data could be considered valid or reliable. For example, for the question "Does the agency have a QI policy and procedure," the evaluation criteria for determining a yes vs. no answer speaks to an evaluation of sufficiency to identify, monitor, and evaluate clinical and service quality and effectiveness on a systematic and ongoing basis. However, the reviewer notes stated that reviewers should be looking for a company-wide policy/procedure that addresses quality improvement, along with an emphasized note that this element is looking for JUST the policy and/or procedure and its existence. For the question "Does the agency have a QI plan," the evaluation criteria stated "Yes" rating is indicated when the provider	19th Not Met **21st Not Met**

Compliance Indicator	Facts	Analysis	Conclusion
implementation of improvement plans.	Round 3 QSRs, there were deficiencies in the inter-rater policies and procedures (i.e., *Interrater Reliability Quality Assurance Policy*). DBHDS had not completed an evaluation of the QSR source system to establish that the data were valid and reliable.	has a QI plan and a "No" rating indicated that a QI Plan was not provided. This could easily be interpreted as again requiring only the existence of a QI Plan. However, in this instance, the reviewer notes required a much more substantive evaluation was required (i.e., the QI plan addresses the needs of the program with specific areas that have been identified to address, evidence of data being gathered and reviewed, evidence of changes made to the plan as needed to incorporate different aspects, when needs of the program change, as a result of a CAP, or any other reason that would affect the quality improvement of the program.) • In addition to the lack of clarity in the evaluation criteria and other guidance, based on the findings from the 20th Period QSR report for CI 53.3, for Round 3 QSRs, there were deficiencies in the inter-rater policies and procedures (i.e., *Interrater Reliability Quality Assurance Policy*) and the relevant terms of the contract. • At the time of the 19th Period review, DBHDS did not provide a response to the Independent Reviewer's request for evidence to show that the Office of EHA had assessed the QSR data collection methodologies to determine the reliability and validity of the data those methodologies produced. For this review Period, as described with regard to CI 30.8 above, DBHDS had not completed an evaluation of the QSR source system. While the Director of the Office of Clinical Quality Management and vendor staff had completed An External Validation Checklist Quality Management on 8/19/22, based on the inability of the Office of EHA staff to validate the efficacy of the tool, DBHDS could not evidence that this was a process sufficient to establish that the data were reliable and valid in any event. The completed tool also did not show these particular questions and instructions (i.e., the data set) were specifically reviewed. In addition, the checklist was not completed until after the conclusion of Round 3, so it was not applicable to the QSR completed during this study period.	

Compliance Indicator	Facts	Analysis	Conclusion
		1. Does the agency have a QI policy and procedure? Evaluation Criteria: A "Yes" rating is indicated when the provider has a QI policy and procedure sufficient to identify, monitor, and evaluate clinical and service quality and effectiveness on a systematic and ongoing basis. A "No" provider documentation does not confirm provider has a QI policy and procedure. Reviewer Notes Reviewers should be looking for a company-wide policy/procedure that addresses quality improvement. NOTE: This element is looking for JUST the policy and/or procedure and its existence. **2. Does the agency have a QI plan?** Evaluation Criteria: A "Yes" rating is indicated when the provider has a QI plan. A "No" rating indicates that a QI Plan was not provided. Reviewer Notes Reviewers should be looking for a quality improvement plan that has been created and specifically addresses the needs of the program with specific areas that have been identified to address. There should be data being gathered and reviewed. There should be changes made to the plan as needed to incorporate different aspects, when needs of the program change, as a result of a CAP, or any other reason that would affect the quality improvement of the program. NOTE: This element is looking for JUST the plan that is specific to the program. The following link is provided, noting that Slides 51-53 address the QI plan vs. program: https://dbhds.virginia.gov/assets/doc/QMD/OL/risk-management-quality-improvement-tips-and-tools-june-2021.pdf	

Compliance Indicator	Facts	Analysis	Conclusion
		3. Is the plan thorough? Evaluation Criteria: A "Yes" rating is indicated when the provider has a QI plan that meets the following criteria: • Be reviewed and updated at least annually, when the provider is issued a licensing citation or CAP, or there is a change in systems or programs; • Define measurable goals and objectives; • Include and report on statewide performance measures, as required by DBHDS; • Monitor implementation and effectiveness of approved corrective action plans pursuant to 12VAC35-105-170; • Include ongoing monitoring and evaluation of progress toward meeting established goals and objects. A "No" rating is indicated when provider documentation only confirms QI policy and procedure, no evidence of a QI plan that meets the previously identified criteria. This element is looking for the evaluation criteria to be included in the Quality Improvement plan and is an "all or nothing" element. Reviewer Notes: Element will be scored "no" if no quality improvement plan is provided or provider documentation only confirms QI policy and procedure, no evidence of a QI plan that meets the previously identified criteria. **4. Is the plan complete?** Evaluation Criteria: A "Yes" rating is indicated when the provider has a QI plan that includes the following elements: design and scope, governance and leadership, feedback/data systems and monitoring, performance improvement projects, systematic analysis, and systemic actions. A "No" provider documentation only confirms QI policy and procedure but does not include all of the required elements	

Compliance Indicator	Facts	Analysis	Conclusion
		indicated by CMS Reviewer Notes: This element is looking for the evaluation criteria to be included in the Quality Improvement plan and is an "all or nothing" element. **5. The quality improvement plan is reviewed annually.** Evaluation Criteria: A "Yes" rating is indicated when review of documentation validated that the quality improvement plan is reviewed annually and by the person designated in the quality improvement policies and procedures. A "No" rating is indicated when review of documentation did not validate that the quality improvement plan is reviewed annually. A "Not Applicable" rating is indicated when there is no quality improvement plan provided. Reviewer Notes: This element is looking for documentation that the Quality Improvement plan (NOT policy/procedure) is reviewed annually. This may be in the form of a signature page, meeting minutes where the plan is reviewed with staff, or another form of documentation. Note: Depending on the documentation provided, reviewer may need to request additional information to demonstrate that the plan was reviewed annually such as meeting minutes from 2021 and 2020 to demonstrate that it was reviewed annually. If the plan has not been in progress for more than a year, element can be scored as "yes" at this point. **6. Providers have active quality management and improvement programs** Evaluation Criteria: A "Yes" rating is indicated when review of documentation validated that the provider maintains an active quality management and	

Compliance Indicator	Facts	Analysis	Conclusion
		improvement and risk management program either as separate plans or combined into one program that addresses both Quality and Risk A "No" rating is indicated when review of documentation did not validate that the provider maintains an active quality management and improvement and risk management program. Reviewer Notes: Documentation that would support "active" programs include evidence of provider staff engagement in QI and/or risk efforts, evidence of meeting/committee/board minutes, etc. Reviewers may utilize the following resources document as a guide to assess the provider's quality management and risk management program. DBHDS Guidance for Risk Management.pdf DBHDS Guidance for a Quality Improvement Program Nov 2020.pdf **7. Describe any findings of No/opportunities for improvement related to the Quality Improvement Plan.** Evaluation Criteria: None Reviewer Notes: Reviewers should document any areas of opportunities for Quality Improvement elements. Any prior elements that were scored "no" for quality improvement elements should have corresponding information in this box for the provider to know what the opportunity for improvement is when they receive their report.	
44.2: Using information collected from licensing reviews and Quality Service Reviews, the Commonwealth identifies providers that have been unable to demonstrate	To implement its CTA pilot project, DBHDS used data collected from licensing reviews that identified DD providers with an approved CAP for licensing regulation	As described above with regard to CI 32.7, to implement its CTA pilot project, DBHDS used data collected from licensing reviews that identified DD providers with an approved CAP for licensing regulation 620.C.2. In addition, based on a document entitled *R3 QIPs CSB List,* the QSR Contractor issued Quality Improvement Plans (QIPs) related to quality improvement programs to eight providers for Round 3 of QSRs. The QIPs	19th Not Met **21st Met***

Compliance Indicator	Facts	Analysis	Conclusion
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.	620.C.2 In addition, based on a document entitled *R3 QIPs CSB List*, the QSR Contractor issued Quality Improvement Plans (QIPs) related to quality improvement programs to eight providers for Round 3 of QSRs. The QIPs provided some basic steps for the provider to take to address the identified deficiencies. However, compliance with these indicators is predicated on the availability of reliable and valid data from the QSRs. As described with regard to 36.1, this study could not confirm that the Commonwealth fully complied with CI 44.2.	provided some basic steps for the provider to take to address the identified deficiencies. However, compliance with these indicators is predicated on the availability of reliable and valid data from the QSRs. As described with regard to 36.1, this study could not confirm that the Commonwealth fully complied with CI 44.2.	

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 continue to place a primary emphasis on remedial and improvement efforts for the data source systems and PMI data collection methodologies.
2. DBHDS should create a protocol to determine how revisions to Process Documents will be screened to determine whether the revisions might impact the accuracy of the existing Attestations.
3. 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.
4. 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.
5. With regard to data reliability and validity, at the time of the 19th Period review, this study noted that the business rules and definitions of the PMI would not necessarily provide a valid denominator for this CI. As further described with regard to CI 42.03, for this 21st Period review, this continued to need resolution.
6. 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.

V.I.1 – V.1.3: For this 21st Period review, the study focused only on those CIs that could not be fully evaluated for Round 3 at the time of the 20th Period. Therefore, the studies for the 20th Period and 21st Period reviews represent a full assessment of all of the QSR processes for the most-recently completed set of QSRs.

At the time of the 20th Period review, based on the Round 3 of QSRs, this study assessed the requirements for a pre-implementation communication plan (i.e., CI 51.3), the policies and outcomes related to QSR Contractor staff identification and reporting of potential abuse, neglect, or exploitation, a potential rights restriction in the absence of an approved plan, or a rights restriction implemented inconsistently with the approved plan (i.e., CI 52.6) and whether QSR staff had training, knowledge, skills, and reviewer qualifications commensurate to what they were expected to review (i.e., CI 53.1), both of which appeared to be met, as well as procedures for inter-rater reliability (i.e., CI 53.3), which did not. The study also reviewed whether QSR reviewers receive and are trained on audit tools and associated written practice guidance (i.e., CI 53.4), which was also not met. This 21st Period review did not include these CIs, since Round 3 remained the most recently completed set of QSRs.

In addition, as this study was intended to provide a complete picture of compliance at the conclusion of Round 3, it did not undertake a review and evaluation of the small number of Round 4 documents DBHDS submitted. Some of these documents might further address Round 3 concerns, but this was outside the scope of this study and will be reviewed at a later date.

While some work remained to be done to ensure the QSR methodologies were sound, it was commendable that DBHDS continued to develop strategies and update methodologies to use the QSR to obtain needed data to drive quality improvement. During the last review, this study reported on the initiative DBHDS staff undertook following the completion of Round 2 QSRs, when they determined that the QSR process and tools needed significant revisions to achieve compliance with the SA and meet the overall intent of DBHDS QSR initiative to assess whether services and supports are provided in a manner consistent with the applicable CIs. For this 21st Period, DBHDS's quality improvement actions were exemplified by Curative Actions related to provider staff competencies, as described with regard to CI 51.4 below and provider reporting measures, as described with regard to CI 44.1 above. While most of these evolving strategies were in the early stages and DBHDS was not yet able to use them in a manner they could attest to as being valid and reliable, they appeared to hold promise for the future.

Section V.I.1: The Commonwealth shall use Quality Service Reviews ("QSRs") to evaluate the quality of services at an individual, provider, and system-wide level and the extent to which services are provided in the most integrated setting appropriate to individuals' needs and choice. QSRs shall collect information through: a. Face-to-face interviews of the individual, relevant professional staff, and other people involved in the individual's life; and b. Assessment, informed by face-to-face interviews, of treatment records, incident/injury data, key-indicator performance data, compliance with the service requirements of this Agreement, and the contractual compliance of community services boards and/or community providers.

This review evaluated all Indicators, except CI 51.3, which was Not Met at the time of the 20th Period, based on Round 3 findings. For this 21st Period Review, based on Round 3 findings, CI 51.1 (annual QSR implementation, resulting in every provider being sampled at least evert two to three years), was Met.

CI 51.2 (face-to-face interviews) was Not Met during Round 3 due to the re-implementation of COVID-19 precautions, which resulted in successful completion of the in-person observation component for only

10 percent of all reviews. For CI 51.4 and CI 51.5, DBHDS did not provide additional documentation it implemented Round 3 modifications of the specific deficiencies identified during the 20th Period review with regard to the adequacy of the tools and guidance (i.e. related to the ability of QSR reviewers to identify potentially unmet clinical needs and to ensure access to treatment as necessary). It is noted that DBHDS submitted a small number of updated documents for Round 4, including some pertinent to this CI. However, this study was intended to provide a complete picture of compliance at the conclusion of Round 3, so it did not undertake a review and evaluation of these Round 4 documents.

In addition to the noncompliant findings for CI 51.4 and CI 51.5 cited above, 21st Period qualitative studies (i.e., Provider Training and Individual Services Reviews) confirmed that DBHDS still needed to make improvements to ensure the processes for evaluating access to needed treatment, competent provider staff and provider quality improvement programs.

Section 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 appropriate to the individuals' needs and consistent with their informed choice, and whether individuals are having opportunities for integration in all aspects of their lives (e.g., living arrangements, work and other day activities, access to community services and activities, and opportunities for relationships with non-paid individuals). Information from the QSRs shall be used to improve practice and the quality of services on the provider, CSB, and system wide levels. This review provided some additional evaluation of all related indicators.

For CI 52.1, the facts and analysis for CI 51.4, described above with regard to both the adequacy of the Round 3 tools and methodologies and the results of qualitative studies, also apply here. These result in a Not Met finding. For CI 52.2 , some improvements continued to be needed with regard to how DBHDS used information, including valid and reliable data, from the QSRs specifically, to improve practice and quality of services, to identify trends, or to address deficiencies at the provider, CSB, and system wide levels. Review and analysis was limited and it was often difficult to identify specific instances of the information being used to improve practice and quality of services in any concrete or meaningful way. As reported previously, the QSR contractor's recommendations to the QIC sometimes tended to be stated in broad terms, which made them difficult to use to inform quality improvement efforts. As reported previously, it likely that this impacted the ability of the QIC and its subcommittees to provide meaningful responses. The QSR Contractor should provide more specific and actionable recommendations that provide more facts and analysis regarding the commonalities and possible root causes that underlie the broadly identified opportunities for improvement.

Overall, though, documentation reviewed for this 21st Period study appeared to indicate that this concern was a by-product of the still maturing and evolving system. Much of DBHDS's focus in the past two Rounds has been on improving the validity of the PCR and PQR questions and the reliability of the data, and on exploring opportunities to expand how the QSR process could be used to address additional needs (e.g., provider reporting measures, provider staff training, access to transportation, etc.). As this process continues to mature, DBHDS appears to have a process in place to review and analyze the QSR findings to determine the most important quality improvement initiatives.

Section V.I.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 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.

Overall, only Indicator 53.2. required additional evaluation for this review, since all of the others had a full review based on Round 3 QSRs during the 20th Period. By the conclusion of this 21st Period, CI 53.1(i.e., requirements for QSR reviewer training and qualifications) and CI 53.2 (i.e., review of 100% of providers across two to three years) were found to be met, but CI 53.3 and CI 53.4 (i.e., inter-rater reliability procedures and consistent standards for the production of reliable data) were not.

V.I.1 Indicators:	Status
51.1 The Commonwealth conducts Quality Service Reviews ("QSRs") annually on a sample of providers, with the goal that each provider is sampled at least once every two to three years, comprised of Person-Centered Reviews ("PCRs") and Provider Quality Reviews ("PQRs"), 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 preferences	Met (21st)
51.2: QSRs utilize information collected from, at a minimum, the following sources for PCRs and PQRs: a. Face-to-face interviews of individual waiver service recipients, family members, or guardians (if involved in the individual's life); case managers; and service providers. b. Record reviews: case management record, the ISP, and the provider's record for selected individuals; the provider's administrative policies and procedures, incident reports, the provider's risk management and quality improvement plans; documents demonstrating compliance with the provider's contractual requirements, as applicable; and the KPA Performance Measure Indicator (PMI) data collected by DBHDS referred to in V.D.2. c. Direct observation of the individual waiver service recipient at each of the provider's service sites (e.g., Residential and/or Day Programs) as applicable for the individuals selected for review.	Not Met (21st)
51.3. The DBHDS QSR Contractor will: a. Prior to conducting QSRs, develop a communications plan and orient providers to the QSR process and expectations. b. Ensure interviews of individual waiver service recipients are conducted in private areas where provider staff cannot hear the interview or influence the interview responses, unless the individual needs or requests staff assistance and, where not conducted in private, it will be documented. Interviews with provider staff are conducted in ways that do not permit influence from other staff or supervisors.	Not Met (20th)
51.4 Reviews assess on a provider level whether: a. Services are provided in safe and integrated environments in the community; b. Person-centered thinking and planning is applied to all service recipients; c. Providers keep service recipients safe from harm, and access treatment for service recipients as necessary; d. Qualified and trained staff provide services to individual service recipients. Sufficient staffing is provided as required by individual service plans. Staff assigned to individuals are knowledgeable about the person and their service plan, including any risks and individual protocols; e. Individuals receiving services are provided opportunities for community inclusion; f. Providers have active quality management and improvement programs, as well as risk management programs.	Not Met (21st)

V.I.1 Indicators:	Status
51.5. The Quality Service Reviews assess on a system-wide level whether: a. Services are provided in safe and integrated environments in the community; b. Person-centered thinking and planning is applied to all service recipients; c. Providers keep service recipients safe from harm and access treatment for service recipients as necessary; d. Qualified and trained staff provide services to individual service recipients. Sufficient staffing is provided as required by individual service plans. Staff assigned to individuals are knowledgeable about the person and their service plan, including any risks and individual protocols e. Service recipients are provided opportunities for community inclusion; f. Services and supports are provided in the most integrated setting appropriate to individuals' needs and consistent with their informed choice.	Not Met (21st)

V.I.2 Indicators:	Status
52.1. 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 consistent with the individual's desires, informed choice and dignity of risk. b. Person-centered thinking and planning is applied and people are supported in self-direction consistent with their person-centered plans, and in accordance with CMS Home and Community Based Service planning requirements. Person centered thinking and planning: i. Is timely and occurs at times and locations of convenience to the individual. ii. Includes people chosen by the individual. iii. Reflects cultural considerations of the individual. iv. Is conducted by providing information in plain language and in a manner that is accessible to individuals with disabilities and persons who have limited English proficiency. v. Provides necessary information and support to ensure that the individual directs the process to the maximum extent possible and is enabled to make informed choices and decisions. vi. Has strategies for solving conflict or disagreement within the process, including clear conflict-of-interest guidelines for all planning participants. vii. Offers informed choices to the individual regarding the services and supports they receive and from whom. viii. Records alternative home and community-based settings that were offered to the individual. ix. Includes a method for the individual to request updates to the plan as needed. c. Services are responsive to changes in individual needs (where present) and service plans are modified in response to new or changed service needs and desires to the extent possible. d. Services and supports are provided in the most integrated setting appropriate to individuals' needs and consistent with their informed choice. e. Individuals have opportunities for community engagement and inclusion in all aspects of their lives. f. Any restrictions of individuals' rights are developed in accordance with the DBHDS Human Rights Regulations and implemented consistent with approved plans.	Not Met (21st)
52.2 Information from the QSRs is used to improve practice and quality of services through the collection of valid and reliable data that informs the provider and person-centered quality outcome and performance results. DBHDS reviews data from the QSRs, identifies trends, and addresses deficiencies at the provider, CSB, and system wide levels through quality improvement processes.	Not Met (21st)

52.3	The summary results of the QSR for each provider (Person-Centered Reviews and Provider Quality Review) will be posted for public review.	Met (21st)
52.4	Summary data will be provided by the QSR vendor to the QIC for review on a quarterly basis to inform quality improvement efforts aligned with the eight domains outlined in section V.D.3.a-h. The QIC or other DBHDS entity utilizes this data to identify areas of potential improvement and takes action to improve practice and the quality of services at the provider, CSB, and system-wide levels.	Met (21st)
52.5.	DBHDS shares information from the QSRs with providers and CSBs in order to improve practice and the quality of services.	Met (21st)
52:6	Whenever a QSR reviewer identifies potential abuse, neglect, or exploitation, a potential rights restriction in the absence of an approved plan, or a rights restriction implemented inconsistently with the approved plan, the reviewer shall make a referral to the DBHDS Office of Human Rights and/or the Department of Social Services adult/child protective services, as applicable	Met (21st)

V.I.3 Indicators:		Status
53.1:	100% of reviewers who conduct QSRs are trained and pass written tests and/or demonstrate knowledge and skills prior to conducting a QSR, and reviewer qualifications are commensurate to what they are expected to review.	Met (20th)
53.2:	Each provider will be reviewed by the QSR at least once every two to three years. Where possible, the QSR samples will target providers that are not subject to other reviews (such as NCI reviews) during the year. Sufficient information is gathered through the samples reviewed to draw valid conclusions for each individual provider reviewed.	**Met (21st)**
53.3:	To address the requirements of a look-behind, inter-rater reliability has been assessed for each reviewer annually, with 80% or higher target against another established reviewer or a standardized scored review, using either live interviewing and review of records or taped video content. Any reviewer who does not meet the reliability standards is re-trained, shadowed, and retested to ensure that an acceptable level of reliability has been achieved prior to conducting a QSR. The contract with the vendor will include a provision that during reliability testing, the reviewer does not have any access to other reviewers' notes or scores and cannot discuss their rating with other reviewers prior to submission.	Not Met (20th)
53.4	QSR reviewers receive and are trained on audit tools and associated written practice guidance that: a. Have well-defined standards including clear expectations for participating providers. b. Include valid methods to ensure inter-rater reliability. c. Consistently identify the methodology that reviewers must use to answer questions. Record review audit tools should identify the expected data source (i.e., where in the provider records would one expect to find the necessary documentation). d. Explain how standards for fulfilling requirements, such as "met" or "not met", will be determined. e. Include indicators to comprehensively assess whether services and supports meet individuals' needs and the quality of service provision.	Not Met (20th)

V.I.1 Analysis of 21st Review Period Findings

Section V.I.1 Assess the Commonwealth's Quality Management System capabilities, documentation and outcomes with regard to the following:
The Commonwealth shall use Quality Service Reviews ("QSRs") to evaluate the quality of services at an individual, provider, and system-wide level and the extent to which services are provided in the most integrated setting appropriate to individuals' needs and choice. QSRs shall collect information through: a. Face-to-face interviews of the individual, relevant professional staff, and other people involved in the individual's life; and b. Assessment, informed by face-to-face interviews, of treatment records, incident/injury data, key-indicator performance data, compliance with the service requirements of this Agreement, and the contractual compliance of community services boards and/or community providers

Compliance Indicator	Facts	Analysis	Conclusion
51.1: The Commonwealth conducts Quality Service Reviews ("QSRs") annually on a sample of providers, with the goal that each provider is sampled at least once every two to three years, comprised of Person-Centered Reviews ("PCRs") and Provider Quality Reviews ("PQRs"), 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 preferences	Since 2020, DBHDS has completed QSRs with the current QSR Contractor on an annual basis. Round 1 was conducted between August 2020 through December 2020. Round 2 (R2) was conducted between February 2021 through June 2021. Round 3 of QSRs began in November 2021 and concluded in May 2022. Based on Round 3 data, the QSR process included 100% of providers over the three year period. DBHDS had taken assertive actions to address	DBHDS selected the current QSR Contactor through a request for proposals (RFP) to conduct quality services reviews (QSRs) to evaluate the quality of home- and community-based services that are provided through Virginia's HCBS DD Waiver program. The QSR includes two components: Provider Quality Reviews (PQRs) and Person-Centered Reviews (PCRs). DBHDS requires all providers and Community Service Boards (CSBs)/Behavioral Health Authorities (BHAs) [hereafter referred to as CSBs] participate in the QSR process. Since 2022, DBHDS has completed QSRs with the current QSR Contractor on an annual basis. Round 1 was conducted between August 2020 through December 2020. Round 2 (R2) was conducted between February 2021 through June 2021. The Round 2 (R2) QSRs were conducted April 2021. Round 3 of QSRs began in November 2021 and concluded in May 2022. The sampling procedure is designed to so that each provider would be sampled at least once every two to three years. However, through Round 2, there were providers who declined to participate. For example, based on the *DBHDS Quality Service Review Annual Summary Fiscal Year 2021*, dated September 30, 2021, in Round 1, 65% of providers declined an in-person interview and observation, while in Round 2, 41% of in-person interviews and observations were declined by either the provider and/or individuals. However, as reported at the time of the 20th Period review, DBHDS had taken assertive actions to address provider non-participation that occurred in the first two Rounds. The Round 3 (R3) state fiscal year (SFY) 2022 QSRs were conducted from November	20th Met **21st Met**

Compliance Indicator	Facts	Analysis	Conclusion
	provider non-participation that occurred in the first two Rounds. This Period's study verified QSR process is comprised of Person-Centered Reviews ("PCRs") and Provider Quality Reviews ("PQRs") 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 preferences. The QSR process includes a review of documents, such as policies and procedures, licensing information, provider records and support coordinator (SC) records including the ISP, interviews and observations of individuals and interviews with providers, support coordinators, individual	2021 through May 2022, reviewing services that occurred during the lookback period of January 2021 through June 2021. The QSR review included a review of 100 percent of the 614 eligible licensed providers and CSBs delivering services. The target sample size approved by DBHDS for this review was 1,200 individuals. Based on Round 3 data, the QSR process included 100% of providers, resulting in compliance with requirement for 100% of providers over the three year period. The process is comprised of Person-Centered Reviews ("PCRs") and Provider Quality Reviews ("PQRs") that are intended 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 preferences. The QSR process includes a review of documents, such as policies and procedures, licensing information, provider records and support coordinator (SC) records including the ISP. The QSR also includes interviews and observations of individuals and interviews with providers, support coordinators, individual family members and/or substitute decision makers.	

Compliance Indicator	Facts	Analysis	Conclusion
	family members and/or substitute decision makers.		
51.2: QSRs utilize information collected from, at a minimum, the following sources for PCRs and PQRs: a. Face-to-face interviews of individual waiver service recipients, family members, or guardians (if involved in the individual's life); case managers; and service providers. B. Record reviews: case management record, the ISP, and the provider's record for selected individuals; the provider's administrative policies and procedures, incident reports, the provider's risk management and quality improvement plans; documents demonstrating compliance with the provider's contractual requirements, as applicable; and the KPA Performance Measure Indicator (PMI) data	The Round 3 methodologies for completion of PCR and PQR tools included face-to-face interviews with individual waiver service recipients, family members, or guardians (if involved in the individual's life), case managers, and service providers, as well as direct observations of the individual waiver service recipient at each of the provider's service sites as applicable for the individuals selected for review. However, based on the Round 3 Aggregate Report, and confirmed in DBHDS staff interviews, the QSR Contractor noted that the Commonwealth of Virginia was impacted by another COVID-19 variant in January	As previously reported at the time of the 20th Period review, in many respects, the QSR Contractor documented a thorough methodology for Round 3 (i.e., *Round 3 Quality Service Review Methodology*), consistent with the requirements of this CI. The QSR process includes a review of documents, such as policies and procedures, licensing information, provider records, and support coordinator records including the ISP. In addition, the planned methodology for completion of PCR and PQR tools included face-to-face interviews with individual waiver service recipients, family members, or guardians (if involved in the individual's life), case managers, and service providers, as well as direct observations of the individual waiver service recipient at each of the provider's service sites as applicable for the individuals selected for review. However, for the most recent completed round of QSRs (i.e., Round 3), the QSR Contractor was rarely (i.e., only 10%) able to complete the required face-to-face interviews and direct observations of individual waiver service recipients, family members, or guardians, case managers and service providers. also resulting in a finding that DBHDS was not able to meet all the requirements for CI 51.2. Based on the Round 3 Aggregate Report, and confirmed in DBHDS staff interviews, the QSR Contractor noted that the Commonwealth of Virginia was impacted by another COVID-19 variant in January 2022, resulting in on-site restrictions that hindered the ability to conduct in-person interviews and observations. When the resumption of in-person on-site reviews was issued by DBHDS on March 2, 2022, the QSR Contractor proceeded with in-person interviews and direct observations resulting in successful completion of the in-person observation component for only 10 percent of all reviews.	20th Not Met **21st Not Met**

Compliance Indicator	Facts	Analysis	Conclusion
collected by DBHDS referred to in V.D.2. c. Direct observation of the individual waiver service recipient at each of the provider's service sites (e.g., Residential and/or Day Programs) as applicable for the individuals selected for review.	2022, resulting in on-site restrictions that hindered the ability to conduct in-person interviews and direct observations. When the resumption of in-person on-site reviews was issued by DBHDS on March 2, 2022, the QSR Contractor proceeded with in-person interviews and direct observations resulting in successful completion of the in-person observation component for only 10 percent of all reviews.		
51.3: The DBHDS QSR Contractor will: a. Prior to conducting QSRs, develop a communications plan and orient providers to the QSR process and expectations. b. Ensure interviews of individual waiver service recipients are conducted in private areas where provider staff cannot hear the interview or influence the interview	Based on the Round 3 communication plan that was completed and disseminated to providers by the time of the 20th Period review, this CI was found to be Not Met at that time, as described below. This CI was not reviewed for this 21st Period study, but details may be found in the IR's 20th Period report.	Based on the Round 3 communication plan that was completed and disseminated to providers by the time of the 20th Period review, this CI was found to be Not Met at that time, as described below. This CI was not reviewed for this 21st Period study, but details may be found in the IR's 20th Period report.	19th Not Met 20th Not Met

Compliance Indicator	Facts	Analysis	Conclusion
responses, unless the individual needs or requests staff assistance and, where not conducted in private, it will be documented. Interviews with provider staff are conducted in ways that do not permit influence from other staff or supervisors.			
51.4 The Quality Service Reviews assess on a provider level whether: a. Services are provided in safe and integrated environments in the community; b. Person-centered thinking and planning is applied to all service recipients; c. Providers keep service recipients safe from harm, and access treatment for service recipients as necessary; d. Qualified and trained staff provide services to individual service recipients. Sufficient staffing is provided as required by individual service plans. Staff assigned to individuals are	At the time of the previous review, this study found that the QSR process did not adequately address the requirement for providers to "access treatment for service recipients, as necessary." The audit tools appear to start with an assumption that what was reflected in the ISP was a correct and complete identification of an individual's needs. The audit tool did not require sufficient data collection to document whether unidentified or inadequately needs	At the time of the 20th Period review, this CI was found to be not met, as described below. Based on review of the PCR and PQR tools for Round 3, the PCR tool had been modified to add some questions about whether the ISP incorporated needs identified in any assessments, the Risk Assessment Tool (RAT) or the Supports Intensity Scale (SIS). This was a positive step forward to address the previously identified deficiencies in the process. However, this did not yet address or resolve the concerns related to the Decision Tree Guide, as updated on 2/3/22, and the lack of any significant emphasis on reviewing clinical needs having to do with attainment or maintenance of functional skills through direct or consultative occupational therapy, physical therapy or speech therapy, and whether those needs have been identified and/or addressed. For this 21st Period review, DBHDS did not provide additional documentation to show any additional changes had been made for Round 3 that addressed these specific deficiencies with regard to the adequacy of the tools and guidance (i.e. related to the ability of QSR reviewers to identify potentially unmet clinical needs and to ensure access to treatment as necessary). It is noted that DBHDS submitted a small number of updated documents for Round 4, including pertinent to this CI. However, this study was intended to provide a complete picture of compliance at the conclusion of Round 3, so it did not undertake a review and evaluation of these Round 4 documents Some of these documents might further address Round 3 concerns, but this was outside the scope of this study and will be reviewed at a later date. During the 21st Period, the Independent Reviewer commissioned an Individual Services	20th Not Met **21st Not Met**

Compliance Indicator	Facts	Analysis	Conclusion
knowledgeable about the person and their service plan, including any risks and individual protocols; e. Individuals receiving services are provided opportunities for community inclusion; f. Providers have active quality management and improvement programs, as well as risk management programs.	might exist or be accessed "as necessary". Guidance materials for first- level reviewers were missing any significant emphasis on reviewing clinical indicators or needs having to do with attainment or maintenance of functional skills through direct or consultative occupational therapy, physical therapy or speech therapy, and whether those needs have been identified and/or addressed. For this 21st Period review, an Individual Services Review qualitative study specifically evaluated whether the Commonwealth's QSR consultants and process are sufficient to meet the requirements of CI 51.4(c) (i.e., providers keep service recipients safe from harm, and access treatment for	Review Study of Individuals with Complex Medical Needs that specifically evaluated whether the Commonwealth's QSR consultants and process are sufficient to meet the requirements of CI 51.4(c) (i.e., providers keep service recipients safe from harm, and access treatment for service recipients as necessary). The findings of that study illustrated that QSR reviewers did not consistently identify clinical indicators or needs that could result in risk of harm or lack of access to treatment as necessary. The findings included that based on the documents available for review, the QSR reviewers failed to identify • 6 of the 7 individuals (86%) who needed assessments or consultations • Of the 5 individuals whose ISPs needed to be modified, three were modified, but the QSR reviewers did not identify the two (100%) whose ISPs were not modified • 11 of the 15 individuals (73%) who needed dental care, and • 0 of 4 of individuals (100%) who received less than 80% of hours of nursing services that they were authorized to receive. In addition, for this 21st Period, as outlined in a Curative Action #10 Training, dated 10/29/21, the Parties agreed to assign responsibility for assessment of providers' implementation of the training and core competency-based training program to a more specifically designed assessment incorporated into the QSR process conducted by the QSR Contractor. This began for Round 3 and is relevant to CI 51.4(d) (i.e., qualified and trained staff provide services to individual service recipients). For this 21st Period, the Independent Reviewer commissioned a qualitative study focused on the related Provisions (i.e., V.H.1 and V.H.2) and the implementation of this Curative Action #10. Based on the findings of this report, this method of assessing competence of the DSP/DSP Supervisor workforce competency was much improved over previous processes. However, the study found that DBHDS had not demonstrated achievement of CI 49.2 (i.e., 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). While the QSR review process initiated during the 3rd round appeared sound and the Health, Safety and Wellbeing alert process ensured timely notification of the provider and DBHDS regarding any identified competency concern, the process to aggregate and analyze the data to measure achievement of the outcomes required in the	

Compliance Indicator	Facts	Analysis	Conclusion
	service recipients as necessary). Based on the findings of that study, QSR reviewers did not consistently identify clinical needs that could result in risk of harm or lack of access to treatment as necessary. Two additional qualitative studies found that QSR processes did not yet provide valid and reliable data to form the bases for the assessments required for CI 51.4(d) and 51.4(f). For this 21st Period review, the QSR Contractor provided a crosswalk of the specific PCR and PQR elements the QSR Contractor considers in making the required assessments for criteria a.-f. for this CI assessment of provider level findings assessment of provider	Compliance Indicator has not yet been finalized. DBHDS staff noted that they could not yet determine the numerator and denominator, as required by the Indicator, or attest to the reliability and validity of the data collected through the QSR process. Therefore, sufficient evidence was not yet available to determine the that the Commonwealth could show it was reliably using the QSR process to perform the assessment required by CI 51.4(d) . With regard to CI 51.4(f) (i.e., providers have active quality management and improvement programs, as well as risk management programs), as described with regard to CI 44.1 above, this quality and risk management study found that, overall, the relevant questions, evaluation criteria and additional guidelines did not provide a clear procedure for addressing each of the specific criteria defined in the CI as necessary to the assessment and determination of the adequacy of providers' quality improvement programs. In addition, as reported with regard to CIs 36.1., 38.1, and CI 44.1 there were other factors negatively impacting the validity and reliability of the data collected in the QSR process. The Commonwealth provided a Process Document entitled *Quality Service Review Methodology*, dated 6/24/22. It referenced the QSR Contractor's methodology documents and also referenced the "WaMS data attestation and Process document." As described with regard to CI 36.1 above and elsewhere throughout this report for V.I.1-V.I-3, DBHDS has not yet established that the QSR Contractor's methodology yields valid and reliable data. In addition, there is not a single Process Document of Attestation for WaMS, as these documents must be specific to the purpose for which the data set will be used. DBHDS also did not provide an Attestation to verify a determination that QSR data are reliable and valid for compliance reporting. Finally, at the time of the 20th Period review, this study requested a crosswalk or listing of the specific PCR and PQR elements the QSR Contractor considers in making the required assessments for criteria a.-f. for this CI, and used the information provided to create a crosswalk. It was concerning that, based on the crosswalk, input from individuals, in particular, but also families, was used only minimally in the assessment of provider level findings. For this 21st Period review, the QSR Contractor provided a crosswalk for Round 3 reporting that appeared to be more inclusive of individual responses.	

Compliance Indicator	Facts	Analysis	Conclusion
	level findings.		
51.5: The Quality Service Reviews assess on a system-wide level whether: a. Services are provided in safe and integrated environments in the community; b. Person-centered thinking and planning is applied to all service recipients; c. Providers keep service recipients safe from harm and access treatment for service recipients as necessary; d. Qualified and trained staff provide services to individual service recipients. Sufficient staffing is provided as required by individual service plans. Staff assigned to individuals are knowledgeable about the person and their service plan, including any risks and individual protocols e. Service recipients are provided opportunities for community inclusion; f. Services and supports are provided in the most	For this 21st Period review, the facts and analysis for CI 51.4 above also apply here and result in a Not Met finding.	For this 21st Period review, the facts and analysis for CI 51.4 above also apply here and result in a Not Met finding.	20th Not Met **21st Not Met**

Compliance Indicator	Facts	Analysis	Conclusion
integrated setting appropriate to individuals' needs and consistent with their informed choice.			

V.I.2 Analysis of 21st Review Period Findings

Section 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 appropriate to the individuals' needs and consistent with their informed choice, and whether individuals are having opportunities for integration in all aspects of their lives (e.g., living arrangements, work and other day activities, access to community services and activities, and opportunities for relationships with non-paid individuals). Information from the QSRs shall be used to improve practice and the quality of services on the provider, CSB, and system wide levels.

Compliance Indicator	Facts	Analysis	Conclusion
52.1: 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 consistent with the individual's desires, informed choice and dignity of risk. B. Person-centered thinking and planning is applied and people are supported in self-direction consistent with their person-	For this 21st Period review, the facts and analysis for CI 51.4 above also apply here (i.e., for the criteria A: Individuals' needs are identified and met, including health and safety consistent with the individual's desires, informed choice and dignity of risk; and C: Services are responsive to changes in individual needs (where present)	For this 21st Period review, the facts and analysis for CI 51.4 with regard to both the adequacy of the Round 3 tools and methodologies and the results of qualitative studies above also apply here. The QSR assessments are not adequate to provide valid and reliable result in a Not Met finding. Specifically, the relevant facts and analysis addressed needs for improvement in the assessment of the following criteria for CI 52.1 • A: Individuals' needs are identified and met, including health and safety consistent with the individual's desires, informed choice and dignity of risk; and • C: Services are responsive to changes in individual needs (where present) and service plans are modified in response to new or changed service needs and desires to the extent possible.	20th Not Met **21st Not Met**

Compliance Indicator	Facts	Analysis	Conclusion
centered plans, and in accordance with CMS Home and Community Based Service planning requirements. Person centered thinking and planning: i. Is timely and occurs at times and locations of convenience to the individual. Ii. Includes people chosen by the individual. Iii. Reflects cultural considerations of the individual. Iv. Is conducted by providing information in plain language and in a manner that is accessible to individuals with disabilities and persons who have limited English proficiency. V. Provides necessary information and support to ensure that the individual directs the process to the maximum extent possible and is enabled to make informed choices and decisions. Vi. Has strategies for solving conflict or disagreement within the process, including clear conflict-	and service plans are modified in response to new or changed service needs and desires to the extent possible. These result in a Not Met finding		

Compliance Indicator	Facts	Analysis	Conclusion
of-interest guidelines for all planning participants. Vii. Offers informed choices to the individual regarding the services and supports they receive and from whom. Viii. Records alternative home and community-based settings that were offered to the individual. Ix. Includes a method for the individual to request updates to the plan as needed. C. Services are responsive to changes in individual needs (where present) and service plans are modified in response to new or changed service needs and desires to the extent possible. D. Services and supports are provided in the most integrated setting appropriate to individuals' needs and consistent with their informed choice. E. Individuals have opportunities for community engagement and inclusion in all aspects of their lives. F. Any restrictions of			

Compliance Indicator	Facts	Analysis	Conclusion
individuals' rights are developed in accordance with the DBHDS Human Rights Regulations and implemented consistent with approved plans.			
52.2 Information from the QSRs is used to improve practice and quality of services through the collection of valid and reliable data that informs the provider and person-centered quality outcome and performance results. DBHDS reviews data from the QSRs, identifies trends, and addresses deficiencies at the provider, CSB, and system wide levels through quality improvement processes.	For this 21st Period review, DBHDS did not specify any examples of how it used information from the QSRs to improve practice and quality of services, to identify trends, or to address deficiencies at the provider, CSB, and system wide levels. Based on review of the last four quarters of QIC minutes provided for review, DBHDS reviewed QSR information to some degree in three of four meetings	For this 21st Period review, DBHDS did not specify any examples of how it used information from the QSRs to improve practice and quality of services, to identify trends, or to address deficiencies at the provider, CSB, and system wide levels. Based on review of the last four quarters of QIC minutes provided for review, as described in detail below with regard to CI 52.4, DBHDS reviewed QSR information to some degree in three of four meetings. However, review and analysis was limited and it was often difficult to identify specific instances of the information being used to improve practice and quality of services in any concrete or meaningful way. The most substantive review took place at the meeting on 9/27/21, when QSR staff presented on the 2021 QSR Report. This presentation included a review of data and identified trends between Round 1 and Round 2. It also identified opportunities for improvement, but these were very broadly stated and not adequate for use to improve practice and quality of services. Based on a review of the *QSR Round 3 Aggregate Report,* and as described with regard to CI 52.5 below, this remained a concern for Round 3. Overall, it appeared this concern was a by-product of the still maturing and evolving QSR system of data gathering, review and analysis. Much of the focus in the past two Rounds has been on improving the validity of the PCR and PQR questions and the reliability of the data, and on exploring opportunities to expand how the QSR process could be used to address additional system needs (e.g., provider reporting measures, provider staff training, access to transportation, etc.). As the process continues to mature, it appears that DBHDS has a process in place to review and analyze the QSR results for meaningful quality improvement. As described with regard to CI 36.1, CI38.1, CI 51.4, CI 51.5 and CI 52.1 above, DBHDS had not yet demonstrated the QSR information reported to and used by the	**20th Not Met** **21st Not Met**

Compliance Indicator	Facts	Analysis	Conclusion
		QIC and its subcommittees resulted from the collection of valid and reliable data.	
52.3: The summary results of the QSR for each provider (Person-Centered Reviews and Provider Quality Review) will be posted for public review.	DBHDS provided a link to the QSR Round 3 Aggregate Report posted on DBHDS website. This report provided provider-specific results.	DBHDS provided a link to the QSR Round 3 Aggregate Report posted on DBHDS website. This report provided provider-specific results.	20th Met **21st Met**
52.4. Summary data will be provided by the QSR vendor to the QIC for review on a quarterly basis to inform quality improvement efforts aligned with the eight domains outlined in section V.D.3.a-h. The QIC or other DBHDS entity utilizes this data to identify areas of potential improvement and takes action to improve practice and the quality of services at the provider, CSB, and system-wide levels.	The QSR Contractor provided summary data to the QIC for quarterly review aligned with the KPA domains.	The QSR Contractor provided summary data to the QIC for quarterly review aligned with the KPA domains, and there was some evidence, as reported at the time of the previous review, that the QIC and subcommittees were considering the information for purposes of quality improvement. While this minimally met the requirements for this CI, there was room for considerable improvement in terms of both the QSR presentations and the meaningful use of them by the QIC and its subcommittees. Based on review of the QIC minutes available from 9/27/21 through 6/27/22, the QSR presentations and discussion are described below: • On 9/27/21, the QSR provided a review of FY 2021 data to the QIC. This included a comparison of Round 1 and Round 2 findings and a description of opportunities for improvement. As reported previously and as described below with regard to CI 54.5, some of the QSR contractors recommendations to the QIC were stated in very broad terms, which made them difficult to use to inform specific quality improvement initiatives with measurable goals. • On 12/13/21, although there was not a QSR presentation, the QIC subcommittees responded to the recommendations made at the meeting on 9/27/21. Many of their responses reported on related work already underway, rather than on requests for additional or specific data that might allow the development of a more focused quality improvement initiatives. One notable exception to the latter was the RMRC response to the QSR recommendation that protocols for physical and behavioral risks are	**20th Met** **21st Met**

Compliance Indicator	Facts	Analysis	Conclusion
		documented and that ISPs are revised to include outcomes and supports for individuals' risks of harm. The RMRC responded that they would like additional information to further understand how to best address this recommendation, noting that a study of the initial implementation of the fall prevention QII found that 74% of individuals with fall risk identified in their RATs had additional supports incorporated into the ISP. The CMSC often noted specific ongoing initiatives and stated they would incorporate recommendations or possibly refer the recommendation to a KPA workgroup. • On 3/28/22, QSR staff again presented on the 2021 Annual QSR Report. All recommendations were the same as those presented on 9/27/22. Based on review of the QSR presentation at that time, it did not appear to contain any additional analysis of consequence beyond what was presented six months earlier. The QIC noted that the information was much the same and took no further action. It would have been more meaningful if the QIC had directed the QSR Contractor to work with the subcommittees to report on any actions taken of progress made with regard to the previous recommendations. • On 6/27/22, the QIC minutes noted that, due to time constraints, the QSR report planned for the meeting was not presented. However, the membership received copies of the written presentation for their own review. Based on review of the presentation, entitled *Quality Service Review Report to QIC*, dated June 2022, the presentation was limited to one slide that described the basic parameters of the recently completed Round 3 (i.e., sample sizes, dates of reviews) and noted the increased focus on Employee Competency/Training and Person-Centered Care. Otherwise, the presentation stated only that provider and CSB Reports were being sent to providers between April 4, and May 31, 2022. Given that this information was available to provider and CSBs approximately one month before this presentation, it would have seemed feasible to provide some level of overview of the findings at the June QIC meeting.	
52.5: DBHDS shares information from the	DBHDS provided a link to the *QSR Round*	DBHDS provided a link to the *QSR Round 3 Aggregate Report* posted on DBHDS website. This report provided provider-specific results.	**20th Met**

Compliance Indicator	Facts	Analysis	Conclusion
QSRs with providers and CSBs in order to improve practice and the quality of services.	*3 Aggregate Report* posted on DBHDS website. This report provided provider-specific results. The *QSR Round 3 Aggregate Report* provided specific, albeit broad, recommendations to providers and CSBs in order to improve practice and the quality of services in several domains.	The *QSR Round 3 Aggregate Report* provided recommendations to providers and CSBs, presumably in order to improve practice and the quality of services in each of three KPA domains. However, the QSR recommendations were general statements that almost always restated the requirements of the Department's existing regulations, such as "identify risks and harms including the development of monitoring of corrective actions as appropriate." For Health, Safety, and Well-Being Elements, recommendations included: • Licensed provider identification of risks of harm including development and monitoring of corrective actions as appropriate • Licensed provider implementation of risk management processes that adequately address harms and risks of harm • Licensed provider development of policies for medical and behavioral health emergencies • CSBs and providers develop and implement an active quality improvement program sufficient to identify and evaluate clinical and service quality and effectiveness on a systematic and ongoing basis. • CSBs and providers develop a process to document annual review of its quality improvement plan. • CSBs and providers develop and implement an active quality improvement program sufficient to identify and evaluate clinical and service quality and effectiveness on a systematic and ongoing basis. • Protocols for physical and behavioral risks are documented, and that ISPs are revised to include outcomes and supports for individuals' risks of harm. For Community Integration and Inclusion Elements, recommendations included: • Increasing options for individuals to participate in work or what represents meaningful work • Increasing options for individuals to participate in community-based activities of their preference • Supporting individuals to participate in their banking • Providing keys to residence and/or personal bedroom	**21st Met**

Compliance Indicator	Facts	Analysis	Conclusion
		• Supporting individuals in registering to vote • Providing individual choice of housemate • CSBs have a plan to ensure support coordinators' ISP documentation confirms that individuals' assessments are completed annually. • CSBs and providers have a plan to ensure that ISP documentation confirms that quarterly review of the ISP is conducted with the individual. • CSBs document the interventions and supports used prior to the modification of ISPs to show all interventions were attempted even and the less intrusive methods of meeting the need of the individual. This will give a more comprehensive overview and show more knowledge of individual preferences/needs. • CSBs ensure support coordinators revise the ISP based on the assessed changing needs and desires of individuals. • CSBs ensure support coordinator understanding of the expectation for documentation of activities and efforts made to address individual risk. CSBs should provide additional clinical-based training to support coordinators that assists with identification of risks, needs, and change in status. For Provider Competency and Capacity Elements, recommendations included: • Licensed provider development of written policies that determine staff competence • 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 develop a process and maintain documentation that demonstrates DSPs receive ISP-specific training. The process must include documentation of training completion. • 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. While this met the expectation for CI 52.5, going forward, the QSR Contractor should begin to provide more specific and actionable recommendations that provide more	

Compliance Indicator	Facts	Analysis	Conclusion
		insight into the commonalities and possible root causes that underly the broadly identified opportunities for improvement.	
52.6: Whenever a QSR reviewer identifies potential abuse, neglect, or exploitation, a potential rights restriction in the absence of an approved plan, or a rights restriction implemented inconsistently with the approved plan, the reviewer shall make a referral to the DBHDS Office of Human Rights and/or the Department of Social Services adult/child protective services, as applicable.	For Round 3, the QSR methodologies required that if during the review process a reviewer identifies potential abuse, neglect, or exploitation of the individual or a potential rights restriction in the absence of an approved plan, or if the rights restriction is implemented inconsistently with the approved plan, the reviewer will make a referral to DBHDS Human Rights and/or the Department of Social Services Adult/Child Protective Services, as applicable within 24 hours of identification. DBHDS and the QSR Contractor also continued to implement a Health, Safety and Welfare Alert program using a reporting	The *Round 3 Quality Service Review Methodology* states that, if during the review process a reviewer identifies potential abuse, neglect, or exploitation of the individual or a potential rights restriction in the absence of an approved plan, or if the rights restriction is implemented inconsistently with the approved plan, the reviewer will make a referral to DBHDS Human Rights and/or the Department of Social Services Adult/Child Protective Services, as applicable within 24 hours of identification. Copies of these referrals will be sent to both the DBHDS QSR Coordinator and the back-up designee identified by DBHDS. DBHDS operationalized this process through the submission of Health, Safety, Wellbeing (HSW) Alerts. Based on review of the Round 3 QSR Alert tracker, this process was implemented and continued throughout the entirety of Round 3. Also, for this 21st Period review, DBHDS provided a Process Document, entitled *Health, Safety, Wellbeing Alerts Process*. This Version 2 was dated 4/1/21. The document described the process steps to be undertaken at the DBHDS level, beginning with the receipt of HSW Alerts. It also defined the roles and responsibilities for key DBHDS departments and staff, including for membership on a QSR Review Team and for any needed follow-up responses and technical assistance. The process steps also included tracking of Alerts, notifications and documentation of follow-up. Overall, it appeared to be an implementation policy and procedure for the HSW Alert process, and not a Process Document in the sense described in the Curative Action for Data Validity and Reliability. It does not specify any measure to be achieved or identify and/or address any threats to data reliability and validity. However, it is valuable in terms of describing the expected processes for implementation.	20th Met **21st Met**

Compliance Indicator	Facts	Analysis	Conclusion
	template for QSR reviewers to report to DBHDS the circumstances of any reportable potential abuse, neglect, or exploitation of the individual or a potential rights restriction. A Process Document, entitled Health, Safety, Wellbeing Alerts Process, Version 2, was dated 4/1/21. The document described the process steps to be undertaken at the DBHDS level, beginning with the receipt of HSW Alerts. It also defined the roles and responsibilities for key DBHDS departments and staff, including for membership on a QSR Review Team and for any needed follow-up responses and technical assistance		

V.I.3 Analysis of 21st Review Period Findings

Section V.I.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 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.

Compliance Indicator	Facts	Analysis	Conclusion
53.1: 100% of reviewers who conduct QSRs are trained and pass written tests and/or demonstrate knowledge and skills prior to conducting a QSR, and reviewer qualifications are commensurate to what they are expected to review.	This CI was found to be met for Round 3 at the time of the 20th Period review and was not reviewed for this 21st Period study. Please refer to the Independent Reviewer's Report to the Court for the 20th Period.	This CI was found to be met for Round 3 at the time of the 20th Period review and was not reviewed for this 21st Period study. Please refer to the Independent Reviewer's Report to the Court for the 20th Period.	17th Not Met 20th Met
53.2: Each provider will be reviewed by the QSR at least once every two to three years. Where possible, the QSR samples will target providers that are not subject to other reviews (such as NCI reviews) during the year. Sufficient information is gathered through the samples	The Round 3 QSRs were conducted from November 2021 through May 2022, reviewing services that occurred during the lookback period of January 2021 through June 2021. The QSR review included a review of 100 percent of the 614 eligible licensed	The Round 3 QSRs were conducted from November 2021 through May 2022, reviewing services that occurred during the lookback period of January 2021 through June 2021. This Round of QSR reviews included a review of 100 percent of the 614 eligible licensed providers and CSBs delivering services. As a result, 100% of providers have been reviewed at least in the past three Rounds.	20th Not Met **21st Met**

Compliance Indicator	Facts	Analysis	Conclusion
reviewed to draw valid conclusions for each individual provider reviewed.	providers and CSBs delivering services. As a result, 100% of providers have been reviewed at least in the past three Rounds.		
53.3: To address the requirements of a look-behind, inter-rater reliability has been assessed for each reviewer annually, with 80% or higher target against another established reviewer or a standardized scored review, using either live interviewing and review of records or taped video content. Any reviewer who does not meet the reliability standards is re-trained, shadowed, and retested to ensure that an acceptable level of reliability has been achieved prior to conducting a QSR. The contract with the vendor will include a provision that during reliability testing, the reviewer does not have any access to	Based on an assessment of Round 3 (inter-rater reliability) IRR procedures, this CI was found to be not met at the time of the 20th Period review and was not reviewed for this 21st Period study. Please refer to the Independent Reviewer's 20th Period Report to the Court.	Based on an assessment of Round 3 IRR procedures, this CI was found to be not met at the time of the 20th Period review and was not reviewed for this 21st Period study. Please refer to the Independent Reviewer's 20th Period Report to the Court.	17th Not Met 20th Not Met

Compliance Indicator	Facts	Analysis	Conclusion
other reviewers' notes or scores and cannot discuss their rating with other reviewers prior to submission.			
53.4: QSR reviewers receive and are trained on audit tools and associated written practice guidance that: a. Have well-defined standards including clear expectations for participating providers. b. Include valid methods to ensure inter-rater reliability. c. Consistently identify the methodology that reviewers must use to answer questions. Record review audit tools should identify the expected data source (i.e., where in the provider records would one expect to find the necessary documentation). d. Explain how standards for fulfilling requirements, such as "met" or "not met", will be determined. e. Include indicators to comprehensively assess whether services and	For this CI, the 20th Period study was based findings on Round 3 training procedures and tools, all of which were complete at the time of this review. Therefore, the Not Met finding of the 20th Period review was current for the most recently completed study and was not reviewed for this 21st Period study. Please refer to the Independent Reviewer's 20th Period Report to the Court.	For this CI, the 20th Period study was based on findings of Round 3 training procedures and tools, all of which were complete at the time of this review. Therefore, the Not Met finding of the 20th Period review was current for the most recently completed study and was not reviewed for this 21st Period study. Please refer to the Independent Reviewer's 20th Period Report to the Court.	19th Not Met 20th Not Met

Compliance Indicator	Facts	Analysis	Conclusion
supports meet individuals' needs and the quality of service provision.			

Recommendations:

1. DBHDS should ensure the QSR Contractor develops and implements additional training, too questions and protocols to address gaps with regard to previously unidentified needs (e.g., the l of any significant emphasis on reviewing clinical indicators and needs having to do with attainment or maintenance of functional skills through direct or consultative occupational therapy, physical therapy or speech therapy, and whether those needs have been identified and/or addressed.)
2. The QSR Contractor should begin to provide more specific and actionable recommendations that provide more insight into the commonalities and possible root causes that underlie the broadly identified opportunities for improvement.

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)
CLO	Community Living Options
CM	Case Manager
CMS	Center for Medicaid and Medicare Services
COVLC	Commonwealth of Virginia Learning Center
CQI	Community Quality Improvement
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 Aging and Rehabilitative 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
E1AG	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
HSN	Health Services Network
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
OCQI	Office of Continuous Quality Improvement
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
RAT	Risk Assessment Tool
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
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