# 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, 2023 – September 30, 2023

Respectfully Submitted By

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Independent Reviewer
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# I. EXECUTIVE SUMMARY

This is the Independent Reviewer's Twenty-third 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 progress during the past year, with a primary focus on the Twenty-third Review Period, April 1, 2023 – September 30, 2023.

At this late stage of the Agreement, the Parties had agreed, in March 2023 and again in July 2023, to target the Independent Reviewer's studies and monitoring for this Report on certain of the Consent Decree's Provisions and 131 of their associated Compliance Indicators. These Indicators represented those that Virginia had not previously met, either at all or twice consecutively, and that had not been removed by the Court. Any Provisions with which the Commonwealth had already achieved Sustained Compliance, as well as any Indicators that Virginia had met twice consecutively were not part of this review.

Leading up to this Report, the Commonwealth had achieved 71 of these 131 remaining Indicators, either fully (30) or conditionally (41). Indicators are met conditionally when Virginia's reported data shows achievement of the requirements, but the relevant data sets have not yet been verified as reliable and valid, and cannot therefore be used for final compliance determinations.

Regarding data reliability and validity, the Twenty-third Period reviews found that the Commonwealth has largely addressed and sufficiently resolved previously identified issues.

Overall, this Period's studies concluded that Virginia has maintained its achievement of 29 Indicators over two consecutive reviews, fully met the requirements of another 38 Indicators that had been only conditionally met previously, and fulfilled a further 33 Indicators for the first time. As a result, the Commonwealth has now achieved 100 of the 131 Indicators studied, bringing Virginia newly into compliance with 15 Provisions of the Consent Decree.

These newly achieved Provisions reflect accomplishments across several areas, including the individual and family supports program, mobile crisis services, case management, mortality reviews, collecting and analyzing data, reporting serious incidents, operating Regional Quality Councils, and maintaining and posting data and documentation. This is an impressive and

extensive list, for which the Commonwealth deserves commendation. These achievements primarily involve Indicators that specify structural and functional aspects of Virginia's statewide service system, such as completing assessments, developing plans, making recommendations, tracking corrective actions, taking enforcement actions, and improving the reliability and validity of data. In addition, for those individuals on DD Waivers, the Commonwealth improved the reliability of non-emergency medical transportation, and increased both the number and percentage of people living in more integrated settings, as well as of adults who are now employed.

This Period's reviews determined that 31 Compliance Indicators are still unmet. These include requirements that involve service outcomes for individuals with IDD. Achieving these, however, is proving more difficult than developing the structures and functions of Virginia's statewide service system. As described in a number of earlier Reports, staffing shortages that had long preceded COVID-19 persisted and worsened during the pandemic. Inadequate pay rates and the difficulty of the work, compared with jobs with similar qualifications, are most frequently cited as the root causes of the Commonwealth's service providers' challenges to successfully recruit and retain the necessary number of essential staff. Virginia's providers continue to report, and this Period's review confirmed that the ongoing shortage of nurses, crisis services workers and direct support professionals undermines the Commonwealth's ability to provide the core services of the Agreement, especially those for people with intense medical and behavioral support needs who live with their families.

For this group of individuals, despite some progress and improvement, Virginia persists in falling short of the Consent Decree's requirements to provide adequate and appropriately delivered behavioral services, conduct initial crisis assessments in individuals' homes or other community settings, deliver needed nursing services, make sure physical and dental exams occur annually, provide participation in integrated day services, and ensure that direct support professionals receive competency-based training.

For the Twenty-Fourth Period review, the Parties have agreed that the Independent Reviewer will target his studies and monitoring on 60 remaining Compliance Indicators across 25 Provisions that the Commonwealth has still not met, either at all or twice consecutively. Any Provisions that have achieved Sustained Compliance, any Indicators that have been fulfilled twice consecutively, and any Indicators that have been removed by the Court will not be reviewed.

The following sections of the Agreement cover these remaining 60 Indicators:

- Individual and Family Support Program,
- Case Management,
- Crisis and Behavioral Services,
- Integrated Day Activities and Supported Employment,
- Community Living Options,
- Family-to-Family and Peer Programs,
- Quality and Risk Management (Provisions V.B. and V.C.1.),
- Mortality Reviews,
- Data to Assess and Improve Quality (Provisions V.D.2.–V.D.4.),
- Public Reporting,
- Quality Improvement, and
- Provider Training.

In closing, it is critical to reiterate that the Consent Decree's goals of providing individuals with IDD the opportunities for community integration, self-determination and quality services depend on the Commonwealth consistently meeting these required service outcomes, in addition to developing its service system's functions and structures.

# II. DISCUSSION OF COMPLIANCE FINDINGS

## A. Methodology

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

- Individual and Family Support Program and Family-to-Family and Peer Programs;
- Case Management;
- Crisis and Behavioral Services;
- Integrated Day Activities and Supported Employment;
- Transportation;
- Community Living Options;
- Services for Individuals with Complex Medical Support Needs;
- Quality and Risk Management;
- Provider Training;
- Quality Improvement Programs;
- Mortality Reviews;
- 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 remaining Compliance Indicators and achieves Compliance with the Provisions.

The Independent Reviewer focused the Twenty-third Period studies on any Provisions with which the Commonwealth had not yet achieved Sustained Compliance, and their associated Compliance Indicators that had not already been met twice consecutively. This included Indicators that had been achieved only once, either fully or conditionally, or not at all, as determined in either the Twenty-first or Twenty-Second Period Report.

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

- "Prove its Case" for having achieved all remaining 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-third Review Period, the Independent Reviewer considered information delivered by Virginia prior to October 15, 2023, and responses to consultant requests for clarifying information up to November 8, 2023. To determine whether the Commonwealth had met the remaining Compliance Indicators and achieved the Provisions studied, the Independent Reviewer considered the findings and conclusions from the consultants' studies, Virginia's planning and progress reports and documents, as well as other sources.

The Independent Reviewer's determinations that Indicators have or have not been met, and the extent to which the Commonwealth 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, Virginia was asked to make its records available that document the proper implementation of the Provisions and the associated remaining Compliance Indicators being reviewed. For each Indicator with a function or performance measure that utilized reported data, the Commonwealth must make available its completed *Process Document* and *Attestation*. With these two documents, Virginia asserts that each of its reported data sets has been verified as reliable and valid. If the Commonwealth performs functions using reported data that have not been verified, or if Virginia 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 would determine that the Commonwealth has "met*" the Indicator. This met* rating is not final and cannot be used for Compliance determinations, but rather is conditional and 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 Virginia did not provide sufficient documentation, the Independent Reviewer determined that the Commonwealth had not demonstrated achievement of the associated Compliance Indicator.

Prior to completing a draft of this Twenty-third Report to the Court for the Parties to review, the Independent Reviewer distributed copies of the consultants' draft studies to DBHDS, and convened an exit call for each study. These calls provided an opportunity for senior staff from Virginia's relevant departments and their subject matter experts to discuss the contents together with the consultants and the Independent Reviewer. The discussions included the identification of any factual errors and misunderstandings, or needed clarifications. The reports were then modified as appropriate.

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-third Report to the Court.

## B. Discussion of Compliance Findings

### *1. Individual and Family Support Programs and Family-to-Family and Peer Programs*

**Background**

The Twenty-second Period study concluded that the Commonwealth had met 14 of the 17 Compliance Indicators associated with the three Provisions (III.C.2a.-i., III.C.8.b., and III.D.5.) related to Individual and Family Support Programs and Family-to-Family and Peer Programs (IFSPs).

Of 11 of Provision III.C.2.a.-i.'s 12 Indicators, Virginia had again met three of them (1.5, 1.8 and 1.12), and had achieved another eight for the first time, namely 1.2–1.4, 1.6, 1.7, and 1.9–1.11. The Commonwealth had not met Indicator 1.1 and so had remained in Non-Compliance with this Provision.

For Provision III.C.8.b.'s two Indicators (17.1 and 17.2), Virginia had again met both of them and maintained Sustained Compliance. For Provision III.D.5.'s three Indicators (19.1–19.3), the Commonwealth had met Indicator 19.1 for the first time, but had not achieved Indicators 19.2 and 19.3, and therefore had remained in Non-Compliance.

This period's study had verified that, in DBHDS's *IFSP State Plan*, the Department had finalized and had been utilizing the required definitions, criteria, satisfaction survey, eligibility guidelines, and other requirements of Provision III.C.2.a.-i.'s eight Indicators that it had met for the first time.

However, there were areas where the Department's progress had been limited. For Indicators 19.2 and 19.3, DBHDS's IFSP Regional Councils were largely non-functional and had not ensured that needed procedures were in place for the Family-to-Family and Peer programs.

The Twenty-second Period study had verified that DBHDS had developed the required documents, and had demonstrated that its IFSP reported data sets were valid and reliable.

**Twenty-third Period Study**

For the Twenty-third Period, the Independent Reviewer retained the same consultant as previously to assess the status of the remaining two IFSP Provisions (III.C.2.a.-i. and III.D.5.), which had not yet been determined to be in Compliance. A total of 12 associated Indicators – nine for Provision III.C.2.a.-i. and three for Provision III.D.5. – had either not been achieved previously or twice consecutively.

Regarding Provision III.C.2.a.-i., Virginia met the requirements of Indicator 1.1 for the first time. DBHDS took actions to substantially revitalize the foundation for a meaningful re-implementation of local community-based support through the IFSP Regional Councils. The Department finalized Regional Council membership, conducted an initial orientation meeting and convened an All-Council meeting. This meeting included a review of the *IFSP State Plan* and an overview of Council orientation materials. The Regional Councils began their work together

in June 2023 with planning meetings. The first IFSP Coordinated Regional Council met in July, and Regional Network Coordinators met in August.

The Regional Councils did not yet have completed work plans, but the planning effort was underway.

The latest study verified that the Commonwealth sustained achievement of this Provision's remaining eight Indicators, 1.2–1.4, 1.6, 1.7, and 1.9–1.11, now meeting them for two consecutive Periods. Once again, Virginia's *IFSP State Plan* included required content, such as criteria for determining applicants most at risk of institutionalization, an on-going communication plan, measurable program outcomes, requirements that outreach materials be provided annually, eligibility for IFSP funding and case management services, eligibility guidelines for IFSP resources and other supports, and an annual participant satisfaction survey regarding the IFSP funding program.

For Provision III.D.5., the Twenty-third Period review found that Virginia had sustained achievement of Indicator 19.1 by providing information to at least 86% of individuals on the waitlist regarding access to Family-to-Family and Peer Mentoring resources. The study also confirmed that DBHDS took needed actions to enhance procedures for the Family-to-Family and Peer Mentoring programs, addressing the specific requirements of Indicators 19.2 and 19.3. These included improvement to the *Virginia Informed Choice Form and Protocol* and additional data tracking and trending capabilities. The Commonwealth met these two indicators for the first time.

See Appendix A for the consultant's full report.

**Conclusion**

Regarding Provision III.C.2.a.-i.'s remaining nine Compliance Indicators, namely 1.1–1.4, 1.6, 1.7, and 1.9–1.11, Virginia has met the requirements of eight of them (1.2–1.4, 1.6, 1.7, and 1.9–1.11) twice consecutively. The Commonwealth has also met the additional Indicator (1.1) for the first time. Therefore, Virginia has achieved Compliance with this Provision for the first time.

Regarding Provision III.D.5.'s three Compliance Indicators, namely 19.1–19.3, the Commonwealth has met the requirements of one of them (19.1) twice consecutively. The Commonwealth has also met the other two Indicators (19.2 and 19.3) for the first time. Therefore, Virginia has achieved Compliance with this Provision for the first time.

## *2. Case Management*

**Background**

As a result of the Twenty-second Period review, the Commonwealth had either fully or conditionally achieved 14 of the 19 Indicators associated with Agreement's four Case Management Provisions: III.C.5.b.i., III.C.5.d., V.F.4. and V.F.5.

Of Provision III.C.5.b.i.'s ten Indicators, Virginia had continued to meet the requirements of four of them, namely 2.1, 2.4, 2.17 and 2.19. Another two Indicators, 2.2 and 2.5, had been achieved for the first time, but a further four Indicators had remained unmet (2.3, 2.16, 2.18 and 2.20).

For Provision III.C.5.d., the Commonwealth had met all six Indicators: 6.1.a, 6.1.b, 6.1, 6.2, 6.3, and 6.4, and had achieved Sustained Compliance for the first time.

Regarding Provision V.F.4., Virginia only conditionally met both Indicators, namely 46.1 and 46.2, since the reliability and validity of the reported data sets were not verified.

The Commonwealth did not meet V.F.5.'s the sole Indicator 47.1.

DBHDS had achieved Indicators 2.2 and 2.5 for the first time after the Department had incorporated its revised case management *On-Site Visit Tool* (OSVT) and definitions into its Support Coordinator Quality Review (SCQR) process. Indicator 2.3 was not met because the selected sample included only adults in the waiver, and not children as required.

Virginia had also not met the requirements of Indicator 2.16. Overall CSB performance continued to fall below the required case management metrics specified in the ten elements, 2.6–2.15. Although several CSBs had successfully met this Indicator's 86% performance measures, only 53% achieved this benchmark for nine of the ten elements. Indicator 2.18 remained unmet because DBHDS had not yet had the opportunity to demonstrate implementing enforcement actions when CSBs underperform following the provision of technical assistance. This lack of opportunity for enforcement was because the performance of all CSBs had improved after receiving such assistance. The Commonwealth also did not achieve Indicator 2.20 since DBHDS and DMAS had not yet implemented joint tracking of Corrective Action Plans (CAPs) to ensure that corrective actions remediate cited issues.

Regarding Indicators 46.1 and 46.2, the Twenty-second Period study confirmed that Virginia, as required, had tracked the number, type and frequency of case management contacts, had implemented the required process to review a sample of data, and had also provided technical assistance to CSBs as needed. These Indicators had only been met conditionally, however, since DBHDS's *Process Document* did not address the Department's assessment concerns regarding the reliability and validity of the data source.

For Indicator 47.1, DBHDS's Case Management Steering Committee (CMSC) had established four indicators, two each in the areas of health and safety and community integration. The Department's data, however, did not show achievement of their required 86% performance measures.

**Twenty-third Period Study**

For this latest review, the Independent Reviewer retained consultants experienced with the Agreement to assess the Commonwealth's status related to its achievement of the three remaining Case Management Provisions (III.C.5.b.i., V.F.4. and V.F.5.), which had not yet been determined to be in Compliance. For these three Provisions, a total of nine related Indicators, 2.2, 2.3, 2.5, 2.16, 2.18, 2.20, 46.1, 46.2 and 47.1, had not been fully achieved previously, or twice consecutively.

DBHDS continued its SCQR process and reviewed records during Fiscal Year 2023, meeting the requirements of Indicator 2.2 for two consecutive periods. The Department added children to the sample for the SCQR process and therefore achieved Indicator 2.3 for the first time. DBHDS also made other improvements to the SCQR process, such as revising various questions and providing clarifying guidance based on user feedback.

This Period's study confirmed that the SCQR-produced data allowed for statewide, CSB and individual level reviews, and that the CMSC again conducted both statewide and CSB level analyses. Virginia has now met Indicator 2.5 for two consecutive periods.

Regarding Indicator 2.16, the CMSC reviewed the results of the SCQR process for Fiscal Year 2023 and determined that just 64% of records reviewed achieved a minimum of nine of the ten elements, which is below the 86% benchmark. This represents a continued steady increase over the 53% in the previous year's report, and the 42% from the year before that. These annual increases indicate that DBHDS's approach is resulting in measurable improvements. The Department has set case management performance standards for the ten selected elements,

implemented a consistent annual process to measure performance, provided technical assistance where needed, and implemented enforcement actions where technical assistance did not resolve underperformance. This SCQR process also identified the element where underperformance has been most resistant to improvement: ensuring that ISPs have specific measurable outcomes. To resolve this issue and meet this element's 86% performance measure, DBHDS will need to invest in a more concerted and targeted quality improvement initiative.

The current study verified that the Commonwealth met the requirements of Indicator 2.18 for the first time. The CMSC recommended to the Commissioner that a CAP be issued for one CSB's failure to meet required targets. This CSB subsequently improved its performance and DBHDS lifted the CAP.

Virginia also met the requirements of Indicator 2.20 for the first time. DBHDS and DMAS instituted joint tracking of CAPs, which are now called Improvement Plans (IPs). This process has demonstrated remediation for a full review period**.**

Regarding the verification of data reliability and validity, DBHDS's *Process Document* that addresses Indicators 2.16, 46.1, 46.2 and 47.1 was thoroughly reviewed during this Period's study. The consultants found that the Department recognizes that its data source (CCS3) is unreliable, and verified that DBHDS has in place and consistently utilizes a reliable mitigation strategy. This will remain until the data source is replaced in 2024. The review concluded that the Department's documentation and functioning data processes are clear and complete, and ensure that the data sets produced are reliable and valid. As a result, the Commonwealth has now fully met the requirements of Indicators 46.1. and 46.2.

Virginia has not yet achieved Indicator 47.1's 86% performance measure for the four indicators. As required, DBHDS is tracking two indicators in the areas of health and safety: ISP implementation and Change in Status, as well as two in the area of community integration: Relationships and Choice. For the health and safety indicators, the Department reported performance at 84% each, which remains below the 86% benchmark. For the two community integration indicators, DBHDS reported performance at 90% and 93% respectively.

See Appendix B for the consultants' full report.

**Conclusion**

Regarding Provision III.C.5.b.i.'s remaining six Compliance Indicators, namely 2.2, 2.3, 2.5, 2.16, 2.18 and 2.20, Virginia has met the requirements for two of them (2.2 and 2.5) twice consecutively. The Commonwealth has met an additional three Indicators (2.3, 2.18 and 2.20) for the first time. However, Virginia did not achieve one Indicator (2.16), so therefore the Commonwealth remains in Non-Compliance with this Provision.

Regarding Provision V.F.4., Virginia has fully met both Indicators, namely 46.1 and 46.2. The Commonwealth has now achieved Compliance with this Provision for the first time.

Regarding Provision V.F.5., Virginia has not met the sole Indicator 47.1, and therefore remains in Non-Compliance with this Provision.

## *3. Crisis and Behavioral Services*

**Background**

Of the Agreement's 13 Crisis and Behavioral Services Provisions, the Twenty-second Period study confirmed that the Commonwealth had once again achieved Sustained Compliance with eight of them (Provisions III.C.6.b.i.A. and B., III.C.6.b.ii.C.–E. and H., III.C.6.b.iii.A. and F.). Virginia had maintained its statewide crisis and behavioral services system, provided mobile crisis teams, offered last resort alternatives to hospitalization, and trained community stakeholders.

Of the five remaining Provisions (III.C.6.a.i.-iii., III.C.6.b.ii.A., III.C.6.b.iii.B., III.C.6.b.iii.D., and III.C.6.b.iii.G.) and their 37 associated Indicators, the same study verified that the Commonwealth had continued to meet 28 Indicators related to crisis and behavioral services, mobile crisis services, crisis stabilization and therapeutic homes for children. Another three Indicators had been met for the first time (7.14, 7.20 and 13.3), five Indicators had remained unmet (7.8, 7.18, 7.19, 10.4 and 11.1), and one Indicator had been newly unmet (8.4).

Regarding Provision III.C.6.a.i.-iii. and its 22 Indicators (7.2–7.23) Virginia had continued to meet 17, and had met an additional two for the first time. DBHDS had completed a gap analysis and set targets and dates to increase the number of behavioral consultants (7.14), and had established a quality review process to track and assesses behavioral services that had been delivered (7.20). Three Indicators (7.8, 7.18, and 7.19) had continued to remain unmet.

For Indicator 7.8, rather than conducting the required 86% of crisis assessments in individuals' homes or other community locations where the crises occur, DBHDS had continued to complete most crisis assessments at hospitals or CSB Emergency Services offices. In the first quarters of Fiscal Year 2023, the Department had reported that only 40% and 41% of crisis assessments occurred in individuals' homes, demonstrating no material change from the results over the previous three years. The 60% who were assessed at hospital emergency departments or CSB offices had been much more likely to be hospitalized, and less likely to receive community-based crisis services and to retain their residential setting.

Regarding the 86% performance measure for Indicator 7.18, DBHDS had reported that for the period reviewed, only 66% of the children and adults who were identified as needing therapeutic consultation (i.e., behavioral supports) had been connected to a behaviorist within 30 days.

For Indicator 7.19's 86% performance measure, the Department's quality review and improvement process had reported that just 76% of the records reviewed had indicated that the individuals had received all four required behavioral support elements.

Regarding Provision III.C.6.b.ii.A.'s seven Indicators (8.1–8.7) the Commonwealth had continued to meet six of them. Indicator 8.4, which had previously been met, was determined to be newly unmet. DBHDS had reported that it did not achieve the 86% performance measure for this Indicator; only 81% of the Crisis Education and Prevention Plans (CEPPs) were completed within 15 days of the crisis assessment.

Regarding Provision III.C.6.b.iii.B.'s four Indicators (10.1–10.4), Virginia had continued to meet 10.1–10.3, but had again failed to achieve Indicator 10.4. The Commonwealth did not meet the 86% performance requirement for identifying a community residence within 30 days for those admitted to Crisis Therapeutic Home (CTH) facilities and psychiatric hospitals. This same requirement had also prevented achievement of Provision III.C.6.b.iii.D.'s sole Indicator 11.1.

Regarding Provision III.C.6.b.iii.G.'s three Indicators (13.1–13.3), Virginia had continued to meet 13.1 and 13.2, and had achieved Indicator 13.3 for the first time, minimally meeting the requirement to implement and operate an out-of-home crisis therapeutic prevention host-home like service for children. Although established, this single host-home like service was barely functioning and seriously underutilized. Due to the excessive distance from families' homes and families' lack of interest, only two of its five Regions had referred any children.

Overall, many components of the Commonwealth's statewide crisis services (i.e., REACH services) had been similarly struggling to fulfill their purpose, with ubiquitous staffing shortages being the primary cause. The two CTHs for children had remained open and operational, although both had been closed for temporary periods during the prior year due to staffing shortages, the pandemic and physical plant issues. Beyond the pandemic's ongoing negative consequences for individuals with IDD who had experienced crises, and for the caregivers who had supported them, the Commonwealth's statewide crisis system had continued to experience significant operational difficulties. For example, REACH teams were challenged to recruit and retain needed staff, and their mobile teams had limited ability to respond to crises on-site.

**Twenty-third Period Review**

For this latest review, the Independent Reviewer retained the same consultants as previously to assess the status of Virginia's efforts toward achieving the Agreement's remaining five Crisis Services Provisions (III.C.6.a.i.-iii., III.C.6.b.ii.A., III.C.6.b.iii.B., III.C.6.b.iii.D., and III.C.6.b.iii.G.), which have not yet been determined to be in Compliance.

The Twenty-third Period study focused on the nine remaining Indicators that have either not yet been met twice consecutively or not at all. These include five Indicators (7.8, 7.14, 7.18, 7.19 and 7.20) associated with crisis and behavioral services; one Indicator (8.4) for mobile crisis service, and three indicators (10.4, 11.1 and 13.3) related to crisis stabilization.

For Indicator 7.8, which was previously unmet, the latest review found that a high percentage of individuals with IDD continued to receive crisis assessments at hospitals or CSB Emergency Departments. As in previous years, this dynamic results in an increased number of children and adults with IDD who are admitted to psychiatric hospitals rather than receiving the mobile crisis service and crisis stabilization services in DBHDS's community-based statewide crisis services system.

During the Twenty-third Period, only 40% of crisis assessments took place in the community in the fourth quarter of Fiscal Year 2023, and 46% in the first quarter of Fiscal Year 2024. These most recent percentages are in line with those reported over the previous three and a half years, and remain nowhere near Indicator 7.8's 86% performance measure. The consultants' latest study noted persistent and substantial variations in the percentages between Regions. For example, Region 1 conducted as few as 0% of crisis assessments at individuals' homes in the first

quarter of Fiscal Year 2023, whereas in Region 3, 57% were conducted during this same quarter. The Commonwealth again did not achieve Indicator 7.8.

Regarding Indicator 7.14, DBHDS continued to significantly exceed this Indicator's performance measure to increase the number of behaviorists by 30% over the July 2015 baseline. Between Fiscal Year 2016 and the first quarter of Fiscal Year 2024, the Department increased the number of behaviorists from 821 to 2,906. DBHDS also completed the required gap analysis and set targets and dates, as required. Virginia has now met this Indicator over two consecutive reviews.

For Indicator 7.18, which was previously unmet, DBHDS again fell short of achieving this Indicator's 86% timeliness benchmark, this time by 15%. Overall, between February and June 2023, only 608 (71%) of the 854 children and adults who were identified for Therapeutic Consultation (i.e., behavioral supports) were connected to a Therapeutic Consultation provider within 30 days. During the previous reporting period, the Department fell 20% short when only 66% were connected within 30 days.

Two of DBHDS's five Regions met the 86% timeliness requirement, illustrating the extent of the substandard performance of its other three Regions, and also that this Indicator's performance measure is achievable. The Department has undertaken a root cause analysis and has identified issues to address and resolve the obstacles to fulfilling this Indicator's requirement.

Regarding Indicator 7.19, which was also previously unmet, DBHDS reported, and the latest study confirmed, that for the 100 behavior plans and related documentation that were reviewed, 88% contained all four required components. This represents a significant improvement over the 136 (76%) reported in the previous Twenty-second Period. The Commonwealth has now achieved this Indicator for the first time.

The consultants' current review of Indicator 7.20 verified that DBHDS has maintained a quality review and improvement process that tracks the authorizations for the number of children and adults needing behavioral services and the number receiving behavioral services. This process also assesses for the five items required by the Indicator. Virginia has now met and sustained its achievement of this Indicator over two consecutive review periods.

Regarding the mobile crisis services Indicator 8.4, DBHDS reported that during the Twenty-third Period, 87% of initial CEPPs were completed within 15 days of the assessment. This is a

significant increase from the Twenty-second Period, when only 81% met the Indicator's 86% performance measure. This time, Regions 1 and 5 each completed 100% within the required 15-day timeline. Region 4, the lowest performing Region, completed 81% on time. The Commonwealth has now re-met this Indicator.

For Indicator 10.4, only one of the five Regions met or exceeded the 86% expectation that individuals with waivers and known to the REACH system have a community residence identified within 30 days of being admitted to CTH facilities and psychiatric hospitals. Over both quarters of the Twenty-third Period, 332 individuals were admitted to hospitals and CTHs, of which only 264 (79.5%) had a community residence identified in the required timeframe. Once again, Virginia has not met this Indicator.

Regarding Indicator 11.1, DBHDS reported that of a total of 58 individuals admitted to CTHs in this Period, 48 (83%) had a community residence identified within 30 days. The Commonwealth's performance has improved, but since the required 86% benchmark was not achieved, this Indicator remains unmet.

For Indicator 13.3, Virginia began this Period with one minimally operational host-home for children experiencing a crisis. During the entire Twenty-third Period, no child was referred to, or accessed this program. Recognizing that the two homes that DBHDS originally created are effectively not functioning, the Department has determined that distance and transportation challenges are significant barriers to family interest. Based on the lack of utilization of this model and the feedback from a focus group, DBHDS is planning to develop alternative prevention supports for children. This time, the Commonwealth did not meet the requirements of this Indicator.

See Appendix C for the consultants' full report.

**Conclusion**

Regarding Provision III.C.6.a.i.-iii.'s remaining five Compliance Indicators, namely 7.8, 7.14 and 7.18–7.20, Virginia has met the requirements of two of them, 7.14 and 7.20, twice consecutively, and has met Indicator 7.19 for the first time. The Commonwealth did not achieve two Indicators, 7.8 and 7.18. Therefore, Virginia remains in Non-Compliance with this Provision.

Regarding Provision III.C.6.b.ii.A.'s remaining one Compliance Indicator, namely 8.4, the Commonwealth has re-met its requirements. Virginia has now achieved Compliance with this Provision for the first time.

Regarding Provision III.C.6.b.iii.B.'s remaining one Compliance Indicator, namely 10.4, the Commonwealth did not achieve its requirements. Therefore, Virginia remains in Non-Compliance with this Provision.

Regarding Provision III.C.6.b.iii.D.'s sole Compliance Indicator, namely 11.1, the Commonwealth did not achieve its requirements. Therefore, Virginia remains in Non-Compliance with this Provision.

Regarding Provision III.C.6.b.iii.G.'s one remaining Compliance Indicator, namely 13.3, the Commonwealth did not achieve its requirements. Therefore, Virginia is in Non-Compliance with this Provision.

## *4. Integrated Day Activities and Supported Employment*

**Background**

The Twenty-first Period study of Virginia's Integrated Day Activities and Supported Employment service system had determined that the Commonwealth had once again maintained Sustained Compliance with Provisions III.C.7.b.i., III.C.7.b.i.A., III.C.7.b.i.B.1.a.-e., III.C.7.b.i.B.2.a.-b., III.C.7.c. and III.C.7.d.

For the remaining Provision III.C.7.a. (that also serves to measure Provision III.C.7.b.), Virginia had again met the requirements of one of its ten associated Indicators, namely 14.1, but did not achieve the other nine, i.e., 14.2–14.10. Therefore, the Commonwealth had remained in Non-Compliance with this Provision.

In July 2023, the Parties had agreed, and the Court had ordered that of these nine Indicators, six of them, namely 14.2–14.7, be removed from the Consent Decree.

In general, the Twenty-first Period study found that DBHDS had made progress toward accomplishing some of Provision III.C.7.a.'s Indicator performance measures, but had regressed with others.

Regarding Indicator 14.8, Virginia had achieved 89% of its overall annual employment target in 2019. Then the pandemic hit, and an expected decline in the number of employed Waiver participants began. The Commonwealth started to turn this decline around in Fiscal Year 2022. As of June that year, there were more individuals employed, but despite this increase and the Department's reduced numerical targets, Virginia had not achieved at least 90% of its revised targets, as required by this Indicator. To meet this employment benchmark for Fiscal Year 2023, significantly more individuals still needed to be employed.

Regarding the number of adults on the DD Waivers and waitlist, the Commonwealth had increased the percentage employed from 19% to 21%. However, this still fell short of the 25% required by Indicator 14.9. And, the increase to 21% in Fiscal Year 2022 contrasts with Virginia's pre-pandemic achievement of 24% in 2019.

For Indicator 14.10, with the expected annual growth in the number of individuals receiving Waiver-funded services, and the Commonwealth's attempts to shift its services system to serving more people in integrated, community-based day settings and away from larger segregated settings, the Parties had agreed in January 2020 to an annual 3.5% increase benchmark. The Twenty-first Period study found that Virginia had not met this Indicator's percentage increase. Instead, the number declined during Fiscal Year 2022. One root cause of this decrease was insufficient provider capacity, to which the pandemic likely contributed. The limited availability of this integrated service model across all Regions suggested that funding rates had been inadequate. The impact of the Commonwealth's funding rate increase for Community Engagement and other day services in July 2022 was too early to be studied during this Twenty-first Period review.

Virginia's reported data for these three Indicators (14.8–14.10) had been supplied by its employment services providers. The *Process Document* for the related data sets had acknowledged weaknesses in four process actions, but had defined an adequate manual work-around for each step.

**Twenty-third Period Study**

For this latest review, the Independent Reviewer retained the same consultants as previously to assess the status of the Commonwealth's compliance with the one remaining Integrated Day Activities and Supported Employment Provision, namely III.C.7.a., which had not yet been determined to be in Compliance. The study focused on its three Indicators, 14.8, 14.9 and 14.10,

all of which had not been achieved previously and had not been removed by the July 2023 Court Order.

Regarding Indicator 14.8, Virginia increased the number of employed individuals by 13% in Fiscal Year 2023. Although a positive trend, the Commonwealth again did not meet this Indicator's requirement of achieving 90% of its annual target.

Virginia's data showed that 23% of the 21,107 adults (aged 18 to 64) receiving Waiver services or on the waitlist were employed during the Twenty-third Period. Even though this represents an increase over the 21% reported in the previous study from a year ago, the Commonwealth has still not met Indicator 14.9's 25% benchmark.

In 2018, when Virginia began maintaining records of the number and percentage of individuals authorized to participate in employment or day services in integrated settings, 25.2% of adults with DD Waiver services were served in such settings. Although not sufficient to achieve Indicator 14.10's required 3.5% annual increase, this percentage had increased to 28.5% by 2020. However, in 2021 and 2022, the percentage steadily decreased to 19.7%. Between March 2022 and March 2023, the number of adults increased by 158 (from 3,096 to 3,254). However, because the overall Waiver population also grew by 638 adults (from 15,691 to 16,329), the percentage authorized for these services increased only slightly from 19.7% to 19.9%. This latest result from March 2023 remains substantially less than the 25.2% baseline established in 2018.

Because the Twenty-third Period review found that the percentage of Waiver participants in integrated settings increased by only 0.2%, the Commonwealth again did not meet Indicator 14.10's requirement.

See Appendix D for the consultants' full report.

**Conclusion**

Regarding Provision III.C.7.a.'s remaining three Compliance Indicators, namely 14.8–14.10, Virginia has not achieved any of them. Therefore, the Commonwealth remains in Non-Compliance with this Provision.

## *5. Transportation*

**Background**

The review conducted for the Twenty-first Period Report had determined that the Commonwealth had maintained its achievement of six of Transportation Provision III.C.8.a.'s eight Indicators that it had met previously (namely, 16.1 and 16.3–16.7). Virginia had also fulfilled the requirements of Indicator 16.8 for the first time, but had not met the remaining Indicator 16.2.

DMAS had continued to include performance standards and timeliness requirements in its transportation contracts, and had fined its provider for failure to meet these standards (Indicator 16.1). The Department had updated its contract with Modivcare, which had continued to separate IDD users in its data analysis and quality improvement processes (16.3). It had also ensured DD Waiver users had opportunities to participate on Regional Advisory Boards (16.4), and had created statistically valid samples of users to assess satisfaction quarterly (16.5). DMAS had also continued to convene focus groups (16.6) and to provide Medicaid recipients with information on filing complaints or appeals (16.7).

As mentioned, the Commonwealth had not met Indictor 16.2. However, DMAS had implemented its major new system-wide initiative to electronically measure NEMT reliability. Its methodology offered significant promise, but for the Twenty-first Period review, the new system documented an on-time performance rate of just 54.8%, still well below the Indicator requirement of 86%.

At the time of the last study, the round of completed Quality Service Reviews (QSRs) had included an assessment of whether waiver-funded, agency-provided transportation facilitated participation in community activities and Medicaid services. The level of reported satisfaction of those reviewed by the QSR surpassed Indicator 16.8's 86% requirement.

Following the Twenty-first Period review, Virginia remained in Non-Compliance with Provision III.C.8.a.

**Twenty-third Period Study**

For the latest review, the Independent Reviewer retained a consultant experienced with the Agreement to assess the status of the Commonwealth's achievement of Transportation Provision III.C.8.a. Since six of the Provision's eight Indicators had previously been achieved at least twice consecutively, only two Indicators remained to be monitored: Indicator 16.2, which had not been achieved previously, and Indicator 16.8, which had been met only once.

Regarding Indicator 16.2, in the second quarter of Fiscal Year 2023, DMAS began requiring GPS-based technology for drivers and defined a 15-minute window on either side of the appointment time as 'on-time'. A pickup or drop off time outside this window was considered 'late'. Virginia utilized this methodology to produce valid and reliable data with which to measure achievement of this Indicator's 86% benchmark. The Commonwealth reported that for the second, third and fourth quarters of Fiscal Year 2023, 86.59%, 91.55% and 89.48% of riders respectively received on-time NEPM transportation. This represents a significant achievement.

For Indicator 16.8, DBHDS's QSR utilized tools in Rounds 4 and 5 that included three questions for waiver recipients related to transportation. Responses from two of the questions provided quantitative data for analysis and computation of this Indicator's 86% performance measure. Responses from the third question provided qualitative data to inform future targeted improvement initiatives. The responses from the two quantitative questions were combined into a single percentage score that the latest study found to be sound. The percentage of individuals or their caregivers who indicated having reliable transportation to participate in community activities and Medicaid services was 94.2% in Round 4 and 93.0%, in Round 5; both well exceeding this Indicator's 86% requirement.

See Appendix E for the consultant's full report.

**Conclusion**

Regarding Provision III.C.8.a.'s remaining two Compliance Indicators, Virginia met the requirements of Indicator 16.2 for the first time during the Twenty-second Period. Throughout this same timeframe, the Commonwealth also sustained its achievement of Indicator 16.8, and achieved Compliance with this Provision.

For the Twenty-third Period, Virginia sustained its achievement of both these Indicators. Therefore, the Commonwealth has achieved Sustained Compliance with this Provision.

## *6. Community Living Options*

**Background**

The review conducted for the Twenty-second Period Report had determined that the Commonwealth had met the requirements of 20 of Community Living Options Provision III.D.1.'s 23 Indicators, namely 18.1, 18.3–18.5, 18.7–18.8, and 18.10–18.23. Virginia had sustained its previous achievement of 17 of these Indicators, and had met an additional three Indicators (18.3–18.5) for the first time. Three more Indicators were unmet: 18.2, 18.6 and 18.9, and therefore the Commonwealth remained in Non-Compliance with this Provision.

Through September 2022, Virginia had sustained a six-year trend of increasing percentages of the overall DD Waiver population receiving services in integrated residential settings, and an annual decrease in living in non-integrated settings. While this had translated to an average annual increase of 1.6%, the Commonwealth had not met the 2% annual increase required by Indicator 18.2.

DBHDS's *Provider Data Summary* had demonstrated that Indicator 18.3 had been met for the first time, since 95% of all individuals new to the waiver, including those with Levels 6 or 7 support needs, were living in integrated settings. The Department's same report had also shown a significant increase in the availability of integrated service models statewide, which achieved the requirements of Indicator 18.4 for the first time.

During the Twenty-second Period, DBHDS had established the Developmental Disability Systems Issues and Resolution Workgroup (DDSIRW) to address issues that impact the development, expansion, and maintenance of services, including integrated residential services. By organizing this workgroup and undertaking the challenge of addressing and resolving the barriers to more integrated residential service options statewide, Virginia had achieved Indicator 18.5 for the first time. Once the Department finalizes its plan to increase these options, the Commonwealth will also meet Indicator 18.6.

DBHDS had achieved the 30-day timeliness benchmark for the initial delivery of nursing services to DD Waiver recipients during Fiscal Year 2022, but had not sustained this same accomplishment for Early and Periodic Screening, Diagnosis and Treatment (EPSDT) service recipients. The Department had reported that just 36% of individuals with waiver-funded services and only 18% of children with EPSDT services had received the number of hours of needed nursing services identified in their ISPs at least 80% of the time. Therefore, Virginia once again had not fulfilled the requirements of Indicator 18.9.

The Commonwealth had continued to meet Indicators 18.10–18.13. These require that children be assessed prior to being admitted to nursing or ICF/IDD facilities, and that admissions to nursing facilities be limited only to those who require medical rehabilitation, respite or hospice services. Virginia also provided a *Community Transition Guide* to assist families in preparing to move their children from these institutions to new community-based homes.

Despite having achieved these Indicators, the Commonwealth had not reduced the overall number of children residing in these facilities in recent years. Although some children had been discharged from these facilities into integrated community-based settings, many continued to spend their childhood developmental years living in these institutions.

**Twenty-third Period Study**

For the latest review, the Independent Reviewer retained a consultant experienced with the Agreement to assess whether sufficient evidence existed to determine if Virginia achieved each of Provision III.D.1.'s six remaining Indicators, i.e., 18.2, 18.3–18.6 and 18.9, all of which have either not been achieved previously, or twice consecutively.

DBHDS's data showed that, between March 31, 2022 and March 31, 2023, the Department continued its multi-year positive trend of increasing the percentage of individuals being served in integrated residential settings by 2.3%, exceeding the required 2% benchmark for Indicator 18.2. Since September 2016, the Commonwealth increased the number of individuals living in more integrated settings by 4,570, while reducing the number of individuals living in group homes of more than four beds by 841.

Virginia also significantly increased the availability of integrated services statewide and continued to meet the requirements of Indicator 18.4. Between 2022 and 2023, the percentage of localities with 86% or more individuals with DD Waiver services living in integrated settings increased from 99 (73%) to 127 (94%).

With input from the DDSIRW, DBHDS finalized its plan to increase more integrated residential service options statewide, and so met Indicator 18.6 for the first time.

Regarding Indicator 18.9, DBHDS reported that it did not sustain the required timeliness metric of individuals receiving nursing services within 30 days of the need being identified in their ISPs. Although the Department achieved the timeliness benchmark for 42 Waiver service recipients, again it did not meet this for 12 EPSDT service recipients. Overall, DBHDS did not achieve this required timeliness metric.

In addition, the Department reported that for the first two quarters of Fiscal Year 2023, it did not achieve Indicator 18.9's nursing utilization benchmark. Instead of the required 70%, only 246 (46%) of the 540 individuals whose ISPs had identified the need for nursing services received the number of hours needed at least 80% of the time.

The Twenty-third Period Individual Services Review (ISR) study of 36 individuals with complex medical support needs determined that only 42% received 80% or more of the number of authorized nursing hours. An additional concern from this ISR study was the inconsistency and unreliability of nursing services for 79% of the individuals studied.

For this same Period, the Independent Reviewer also learned and confirmed that Indicator 18.9's three components of its performance measure include significant flaws. This is a major issue – one that DBHDS recognizes – and will require the Department to design and implement an entirely new approach to determining whether individuals with IDD receive 80% of the nursing hours they need. The baseline currently included in this Indicator cannot be utilized, since DBHDS no longer knows the methodology used to establish it, and cannot replicate it.

Additionally, when the Parties agreed to the terms of this Indicator in January 2020, the Commonwealth believed that the number of needed hours of nursing services was specified in individuals' ISPs. When DBHDS learned that this information was in fact often not included, the Department began on July 1, 2020, to instead use the number of authorized hours to represent the number of needed hours. However, DBHDS later determined that the number of authorized nursing hours is often inflated to cover potential changes in need or unexpected events, and is therefore not an accurate substitute for needed hours to be identified in the ISP.

For Fiscal Year 2021, the Department determined that only 30% of individuals received at least 80% of the number of nursing service hours needed. Due to the pandemic, Fiscal Year 2021 was a low point of utilization for many types of services. Since then, DBHDS has reported that the utilization rates for Fiscal Years 2022 and 2023 increased to 36% and 46% respectively. However, because we now know that the number of authorized hours is often inflated, the actual utilization rates are almost certainly higher than these reported rates.

Again for the Twenty-third Period, Virginia did not meet the requirements of Indicator 18.9. Furthermore, if DBHDS continues to use its current tracking and calculation methodology, the Commonwealth will remain unable to accurately report the percentage of nursing hours that individuals receive versus what they need, i.e., the utilization rate.

Virginia has taken steps to expand the availability of nursing services. At the beginning of Fiscal Year 2023, the Commonwealth significantly increased its reimbursement rate so that nurses could be paid more. However, this new rate was set at only 90% of the 2021 market rate for nurses in Virginia. The Commonwealth has yet to see a significant impact from increasing this rate, but hopes that improvement will show in the next reporting Period, as evidenced by increased nursing utilization rates.

To improve nursing utilization rates, Virginia had already expanded its provider stimulant, Jump Start Funding, to include nursing services. More recently, the Commonwealth also refined its nursing training supports and convened stakeholders to identify unresolved barriers to the consistent and timely delivery of nursing services. DBHDS also shared a draft of a proposed *Intense Management Needs Review* process, which the Department designed to assess and monitor the adequacy of management and supports provided to individuals with complex medical needs.

DBHDS previously reported an increase in requests from families, whose children with IDD live in nursing facilities, for further information on community placement into more integrated settings. However, rather than this resulting in a decrease in those children living in nursing facilities, the Department reported that in the Twenty-third Review Period, two more children are living in nursing facilities, and one more child is living in a large ICF/IDD. Although Virginia has met the requirements specified in Indicators 18.10–18.13, DBHDS should continue its efforts to create more supports so that children with complex medical needs can live in integrated community-based settings.

The Department's *Process Documents* and *Attestations* for the Indicators reviewed in this Twenty-third Period study had already been verified in previous reporting periods. DBHDS submitted a list of changes that were made to these processes since the Twenty-second Period review. The consultant's study determined that these changes did not compromise these data quality processes.

See Appendix F for the consultant's full report.

**Conclusion**

Regarding Provision III.D.1.'s remaining six Compliance Indicators, the Commonwealth has met the requirements of five of them, namely 18.2–18.6. Since Virginia did not achieve Indicator 18.9, the Commonwealth remains in Non-Compliance with this Provision.

## *7. Services for Individuals with Complex Medical Support Needs*

**Background**

The Twenty-second Period's Individual Services Review (ISR) study had determined, for the cohort of individuals with IDD reviewed, that the Commonwealth had again not met the requirements of Provision V.I.1.a.-b.'s Indicator 51.4 (subsection c.) or Provision V.I.2.'s Indicator 52.1 (subsections a. and c.). This review's findings were consistent with those of previous ISR studies of individuals with IDD with complex medical support needs: Round 4 of DBHDS's Quality Service Reviews (QSR) process had not identified significant issues and concerns related to their safety and healthcare.

The ISR study had found that the lack of needed in-home nursing care was an obstacle to meeting these individuals' intense healthcare support needs. Of the six people who needed these services but did not receive them, their families and/or sponsors cited the lack of nursing supports as a serious concern.

**Twenty-third Period Study**

For this latest review, the Independent Reviewer retained the same consultants as previously to conduct another ISR study, this time to assess Virginia's status in meeting Provision III.D.1.'s Indicator 18.9, and Provision V.B.'s Indicator 29.20. Neither of these Indicators had been achieved previously, either at all or twice consecutively.

This Period's ISR study focused attention on individuals with SIS level 6 needs (i.e., complex medical needs), who were involved in meetings in August or September 2022 to discuss or review their Individual Supports Plan (ISPs). These ISPs all included an identified need for nursing services. A sample of 24 individuals was then randomly selected from the cohort of the original 36 individuals to provide 90% confidence that the findings from this study can be generalized to the cohort.

Although the intensity and frequency of the specific medical conditions varied among the individuals in the sample, they shared many of the same diagnoses. For example, 96% have choking precautions in place, 79% are being tube-fed, 63% require suctioning, 67% have bowel elimination problems, and 83% have a major seizure disorder. The discrete issues related to the health care needs of every person in the sample are described in the Monitoring Questionnaires, completed after each of the consultants' site visits, and shared with DBHDS.

The ISR consultant nurses who completed the study reported that, in light of the complex and overlapping medical conditions experienced by the people in the sample, nursing services that are consistent, reliable, and skilled are critical for these individuals' health and safety.

Regarding Indicator 18.9, according to the data provided by DBHDS, the table below shows how many individuals received particular percentages of authorized hours of nursing services. Of the 24 people in the ISR selected sample, only 42% received at least 80% of the number of authorized hours. This falls significantly short of the 80% required by Provision III.D.1.'s Indicator 18.9.

| **Percentage of Authorized Hours Received** | | |
|---|---|---|
| # of individuals | % of authorized nursing services received | # of individuals (%) who received at least 80% / less than 80% |
| 5 | 100% | 10 (42%) |
| 5 | 80 – 99% | |
| 6 | 60 – 79% | 14 (58%) |
| 5 | 20 – 59% | |
| 3 | 0 – 19% | |

Given the complicated medical conditions of those in this sample, the lack of nursing services has potentially serious, even grave, consequences, including avoidable and unnecessary out-of-4+home placement or admission to a nursing home. The most serious finding of this latest ISR study was that even some of those who received at least an average of 80% of their authorized nursing services during a specific time period also experienced significant gaps and inconsistent nursing supports. Of the 24 people in this study, 19 received inconsistent and unreliable nursing services. The impact of this lack of consistency, often on an unpredictable basis, was a concern to most of the caregivers.

Regarding Provision V.B.'s Indicator 29.20, the ISR review found that 21 of the people in the sample (87.5%) had an annual physical exam, and three of them (12.5%) did not have this requisite examination. The study had positive findings related to physician orders. All ordered lab work was completed. With one exception, all physician-ordered diagnostic tests and medical specialists' recommendations were completed within the recommended timeframe. Furthermore, all monitoring ordered by the physicians was implemented, including the monitoring of seizures, fluid and food intake, tube feedings, weight fluctuations and positioning protocols.

The ISR study determined that of the 23 individuals with dental coverage, only 15 (65%) had an annual dental exam. This did not achieve Indictor 29.20's requirement that 86% of individuals with dental coverage receive an annual dental exam. Recurring difficulties in obtaining dental care persisted for eight (35%) people in the adjusted sample.

The obstacles to dental care experienced by these people have been identified repeatedly in past ISR studies. Problems include dentists who do not provide sedation, dentists who are uncomfortable with positioning and/or with treating medically challenged people, long distances to reach a qualified dentist, and individual or family resistance to dental appointments. For the cohort of individuals in this study, the Commonwealth did not meet Indicator 29.20.

See Appendix G for the consultants' full report.

**Conclusion**

Regarding Provision III.D.1., for the cohort of 36 individuals in the ISR study, Virginia did not achieve Compliance Indicator 18.9. For this cohort, the Commonwealth remains in Non-Compliance with this Provision.

Regarding Provision V.B., for the cohort of 36 individuals in the ISR study, Virginia did not achieve Compliance Indicator 29.20. For this cohort, the Commonwealth remains in Non-Compliance with this Provision.

## *8. Quality and Risk Management*

**Background**

Seven Provisions, V.B., V.C.1., V.C.4., V.D.1., V.D.2., V.D.3. and V.D.4., and their associated 94 Compliance Indicators specify the Agreement's requirements for Virginia's Quality and Risk Management (QRM) system.

A summary of the Report findings from the Twenty-first and Twenty-second Periods follows.

Twenty-first Period

This study concluded that of Provision V.C.4.'s nine Indicators, namely 32.1–32.9, the Commonwealth had sustained achievement of six of them, 32.1, 32.2, 32.5, 32.6, 32.8 and 32.9. Virginia had met Indicator 32.3 for the first time, but had not achieved the remaining two Indicators, 32.4 and 32.7. The Commonwealth therefore remained in Non-Compliance with this Provision.

For Provision V.D.1.'s eight Indicators, namely 35.1–35.8, Virginia had continued to achieve two of them, 35.2 and 35.4, and had met an additional Indicator, 35.6, for the first time. Another two Indicators, 35.3 and 35.8, had been conditionally met for the first time. The Commonwealth had not achieved the remaining three Indicators, 35.1, 35.5 and 35.7, and so remained in Non-Compliance.

Regarding Provision V.D.2.'s eight Indicators, namely 36.1–36.8, Virginia had met one of them, 36.5, for the first time, and had conditionally achieved another four Indicators, 36.2, 36.4, 36.6 and 36.7. The Commonwealth had not met the remaining three Indicators, 36.1, 36.3 and 36.8, and therefore remained in Non-Compliance.

Regarding Provision V.D.3.'s 24 Indicators, namely 37.1–37.24, Virginia had sustained achievement of ten of them, 37.3, 37.4, 37.8, 37.9, 37.11, 37.13, 37.15, 37.19, 37.21 and 37.23. Another Indicator, 37.17, had been met for the first time, and a further 12 Indicators, 37.1, 37.2,

37.5, 37.6, 37.10, 37.12, 37.14, 37.16, 37.18, 37.20, 37.22 and 37.24, had been conditionally met. The Commonwealth had not achieved the remaining Indicator 37.7, and so remained in Non-Compliance.

For Provision V.D.4., Virginia had not met the sole Indicator 38.1, and remained in Non-Compliance.

Twenty-second Period

This review determined that, for Provision V.B.'s 33 Indicators, namely 29.1–29.33, the Commonwealth had sustained achievement of nine of them, 29.3, 29.5–29.7, 29.9, 29.11, 29.12, 29.31 and 29.32, and one Indicator, 29.15, had moved from conditionally met to fully met. Another four Indicators, 29.2, 29.4, 29.19 and 29.27, had been met for the first time, and a further nine Indicators, 29.1, 29.8, 29.10, 29.14, 29.26, 29.28–29.30 and 29.33, had been conditionally met. Virginia had not achieved the remaining ten Indicators, 29.13, 29.16–29.18, and 29.20–29.25, and therefore remained in Non-Compliance.

Regarding Provision V.C.1.'s 11 Indicators, namely 30.1–30.11, the Commonwealth had sustained achievement of six of them, 30.1–30.3, 30.6, 30.8 and 30.9, and one Indicator, 30.5, had moved from conditionally met to fully met. Another two Indicators, 30.7 and 30.11, had been met for the first time. Virginia had not achieved the remaining two Indicators, 30.4 and 30.10, and so remained in Non-Compliance.

As previous studies had found, the Commonwealth's quality framework had continued to be hampered. Despite Virginia making some steady progress over these two Periods and achieving ten Indicators for the first time, the overall effectiveness of key components of the QRM system, such as identifying and implementing needed improvements, had been undermined due to the lack of collection and analysis of consistent, reliable data. This had remained a critical obstacle to compliance determinations for 27 QRM Indicators that were only conditionally met. A further 22 Indicators had remained unmet.

**Twenty-third Period Study**

For this latest review, the Independent Reviewer retained the same consultants as previously to assess the status of the Commonwealth's achievement of the seven QRM Provisions, V.B., V.C.1., V.C.4., V.D.1., V.D.2., V.D.3. and V.D.4., which had not yet been determined to be in Compliance. The study focused on 59 remaining Indicators, which had not yet been achieved twice consecutively, fully or at all.

Provision V.B.

Of Provision V.B.'s remaining 23 Indicators, Indicator 29.1 moved from conditionally met to fully met, with previously identified threats to data reliability and validity having been addressed. As well, Virginia continued to fulfill the requirements for two previously met Indicators, 29.2 and 29.4. DBHDS maintained it Quality Management System (QMS) with a robust set of policies, procedures and practices for quality improvement, as well as for quality assurance and risk management. The Department's annual plans provided a clear overall conceptualization of quality improvement structures and functions. The QMS descriptions continued to specify responsibilities, policies and procedures for implementation of a quality cycle, as required. The Office of Licensing (OL) and the Office of Human Rights (OHR) fulfilled their defined quality assurance functions regarding providers meeting regulatory requirements. The study verified that OL's review processes included specific methods to address areas where this presented a problem.

Indicators 29.8 and 29.10 also moved from conditionally met to fully met. DBHDS's Office of Clinical Quality Improvement continued to direct contractors performing quality review processes. The Office also collected data from these processes to evaluate the sufficiency, accessibility and quality of services at an individual, service, and systemic level, and to utilize this data to identify opportunities for quality improvement. This Period's review confirmed that the subcommittees of the Quality Improvement Committee (QIC) reported to the QIC and fulfilled their responsibilities as specified. Once again, previously identified threats to data reliability and validity were addressed.

For Indicators 29.13, 29.14, 29.16, 29.17 and 29.18, DBHDS's Risk Management Review Committee (RMRC) oversaw the Department's overall risk management process. However, the Commonwealth did not achieve Indicator 29.13; the latest study found that the RMRC did not review data and identify trends related to allegations of abuse, neglect and exploitation. With data reliability and validity issues addressed, Virginia moved from conditionally met to fully met for Indicator 29.14's requirements to review and analyze data, monitor apparent trends and patterns in certain data, and identify areas for improvement. The RMRC did not fully evaluate whether providers were implementing timely, appropriate Corrective Action Plans (CAPs), however, as required by Indicator 29.16. The Commonwealth also did not achieve Indicator 29.17; given the newness of its revised process, the RMRC did not yet have sufficient data and information to identify trends at least quarterly. As well, Indicator 29.18's requirements were not met, as Virginia failed to achieve the 86% threshold.

DBHDS sustained achievement of Indicator 29.19. The Department continued to require providers to identify individuals at high risk, and to report this information to the Commonwealth.

For Indicators 29.20 and 29.21, DBHDS did not achieve the 86% benchmarks. Annual physical exams were only completed for 76% of people supported in residential settings. Dental exams were only completed for 59% of those with coverage, and only 74% of people with identified behavioral support needs were provided adequate and appropriately delivered services.

Regarding the 95% performance measure for Indicators 29.22–29.25, DBHDS did not achieve Indicator 29.22; it did not submit a data report to evidence the required compliance. For Indicator 29.24, the Department failed to meet the 95% benchmark because only 88.7% of individual service recipients were adequately protected from serious injuries in service settings. DBHDS did achieve Indicators 29.23 and 29.25 for the first time. Respectively, 98% of individual service recipients were free from neglect and abuse by paid support staff, and for 99% of individual service recipients, seclusion or restraints were only utilized after a hierarchy of less restrictive interventions were tried.

The Twenty-third Period review found that another five Indicators, 29.26, 29.28–29.30 and 29.33 all moved from conditionally met to fully met. DBHDS provided the required *Attestations* and related *Process Documents* that addressed previously identified threats to data reliability and validity.

DBHDS also continued to meet Indicator 29.27. The latest study confirmed that at least 75% of people with a job in the community had chosen, or had input into choosing their employment.

Provision V.C.1.

Of Provision V.C.1.'s four remaining Indicators, DBHDS provided documentation for Indicator 30.4 that showed 98.4% of its licensed providers of DD services had been assessed for their compliance with the Licensing Regulations' risk management requirements during their annual inspections. While this percentage was higher than this Indicator's 86% performance measure, the consultants' review of documentary evidence from a sample of 25 licensed providers found agreement with only 52% of the sample. Since this Twenty-third Period study could verify the accuracy of only 52% of the Licensing Specialists' determinations, Virginia once again did not meet the requirements of this Indicator.

The Commonwealth again met the requirements of Indicator 30.7. DBHDS continued to monitor and expand its review of data and information about care concerns at least annually, and determined if any changes to the list of care concerns were necessary. Recommendations were issued to providers and were used to update training and tools to assist providers.

Once again, however, Virginia failed to meet the requirements of Indicator 30.10. The same review of sampled provider documents conducted for Indicator 30.4 could not confirm that DBHDS sufficiently identified the need for CAPs to be written and implemented for all providers, including CSBs, that did not meet the requisite standards. This sample review could not verify that providers were using data at the individual and provider level, including from incidents and investigations, to identify and address trends and patterns of harm and risk of harm in the events reported, as well as in the associated findings and recommendations.

DBHDS again implemented the required procedures for Indicator 30.11. The Twenty-third Period review confirmed that the Department maintained effective licensing processes to monitor provider development and implementation of risk mitigation plans, and issued and tracked implementation of related CAPs.

Provision V.C.4.

The Commonwealth achieved Compliance with Provision V.C.4's and its three remaining Indicators for the first time.

Virginia maintained its achievement of Indicator 32.3. At the time of the prior Twenty-first Period review, OL had in place sufficient processes for assessing compliance with the applicable regulations. For this latest study, DBHDS provided evidence of inspections of any providers that had been non-compliant with risk management requirements due to a lack of training. The Department's submitted spreadsheet also showed completed CAPs for 85% of the inspections.

Regarding Indicator 32.4, DBHDS implemented the required processes for providers determined as non-compliant with training and expertise for staff responsible for the risk management function. The latest review of Virginia's documentation confirmed that 95% of the OL CAPs issued to providers had been completed. The Commonwealth achieved this Indicator for the first time.

Virginia also met the requirements of Indicator 32.7 for the first time. The Twenty-third Period study confirmed that the RMRC used data and information from risk management activities, including mortality reviews, to identify topics for future content. The Committee reviewed risks identified as potential concerns, and developed additional educational content to address these concerns. DBHDS identified providers in need of additional technical assistance or other corrective action, and continued to post on its website substantial guidance for providers and others related to risk management.

Provision V.D.1.

Of Provision V.D.1.'s six remaining Indicators, the Twenty-third Period review found that the Commonwealth did not achieve the requirements of five of them, 35.1, 35.3, 35.5, 35.7 and 35.8.

Regarding 35.1, 35.3 and 35.5, the Quality Review Team (QRT) did not meet to review quarterly data or to develop and/or monitor needed remediation, as required for each of its DD Waivers. DBHDS reported that the QRT had undergone a transfer of ownership to DMAS, and therefore no QRT meetings occurred during the transition.

Virginia again fulfilled the requirements of Indicator 35.6. DMAS remains the single state agency designated to oversee the administration of Virginia's Medicaid program, as well as reporting to the Centers for Medicare and Medicaid Services (CMS). The current study also confirmed that DMAS conducted the required financial audits and financial reporting for each DD Waiver.

For Indicator 35.7, the Commonwealth again did not meet its requirements. DBHDS did not provide evidence to show that a local level or Community Services Board (CSB) annual review of the Waiver performance measures had occurred. As in previous Reports, the data submitted were once more over 14 months old, and therefore were not adequate or useful for CSB quality improvement committees to establish CSB-specific quality improvement activities.

For Indicator 35.8, the Twenty-third Period review found that only 83% of individuals assigned a Waiver slot were enrolled in a service within five months, per regulations. As a result, Virginia did not achieve this Indicator's 86% performance measure.

Provision V.D.2.

Of Provision V.D.2.'s eight Indicators, the Twenty-third Period review confirmed that, for the first time, the Commonwealth met Indicator 36.1. DBHDS issued its *Data Quality Monitoring Plan Source System Report* that included, for 16 source systems, a summary of the improvements the Department had made in the previous year to its data validation controls, key documentation, manual data processing, user interface, and backend structure. Although these improvements were sufficient to achieve the Indicator's minimum requirements, the study found some remaining concerns that DBHDS should address going forward. Chief among these was the failure of the assessment to address potential inter-rater reliability deficiencies and their impact on data validity and reliability.

The latest review found that DBHDS moved Indicator 36.2 from conditionally met to fully met. DBHDS continued to use data collected to complete analyses regarding trends and patterns. The QIC subcommittees and workgroups identified, implemented and tracked the efficacy of Quality Improvement Initiatives (QIIs). The current study also verified that the Department adequately implemented requirements to ensure that its reported data sets were reliable and valid.

DBHDS fulfilled the requirements of Indicator 36.3 for the first time. The Department put in place a process to review and analyze results from the National Core Indicators (NCIs) and Quality Service Reviews (QSR) for meaningful quality improvements. The QIC reviewed NCI and QSR data, discussed quality of services and individual level outcomes, and assigned subcommittees to review recommendations and to report back. The latest review verified that the groups each provided specific NCI and QSR feedback.

The Twenty-third Period study confirmed that Virginia sustained achievement of Indicator 36.5, and, for Indicators 36.4, 36.6, and 36.7, moved from conditionally met to fully met. The review also verified that the Commonwealth met the data reliability and validity requirements of the data sets reported by DBHDS related to these Indicators. The specified quality committees and workgroups established goals and monitored progress. The Department's documentation described that these groups functioned consistently with Indicator 36.4's requirements. DBHDS began using the *Process Document* template for documenting the methodologies for all Performance Measure Indicators (PMIs) necessary to again meet Indicator 36.5. Regarding Indicator 36.6, the Department utilized a system for PMIs that included procedures to track the efficacy of preventative, corrective and improvement measures. For Indicator 36.7, each DBHDS subcommittee and workgroup again conducted presentations that described the approaches used for data collection and analysis to enhance outreach, education or training.

Once again, Virginia did not fulfill the requirements of Indicator 36.8. DBHDS provided relevant data with only one month remaining in the Twenty-third Period, resulting in insufficient time for the consultants and the Independent Reviewer to investigate and verify its quality. The Department also made several potentially significant modifications to the previously proposed methodology that could impact the validity of the required sample. Additionally, DBHDS's current methodology does not appear to fulfill this Indicator's corrective action requirements.

Provision V.D.3.

Of Provision V.D.3.'s 14 remaining Indicators, DBHDS moved from conditionally met to fully met for Indicators 37.1, 37.2, 37.5 and 37.6, with data reliability and validity issues having been addressed. The Department had previously established three Key Performance Areas (KPAs) to address the eight domains. Each KPA workgroup completed the actions required. DBHDS's 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 quality improvement initiatives.

The Twenty-third Period study found that the Commonwealth met the requirements of Indicator 37.7 for the first time. Each PMI described completely and thoroughly the specific steps used to supply the numerator and denominator for calculation. The PMIs detailed key elements needed to ensure the data collection methodology produces valid and reliable data.

Virginia also continued to achieve Indicator 37.17, and Indicators 37.10, 37.12, 37.14, 37.16, 37.18, 37.20, 37.22, and 37.24, moved from having been conditionally met to being fully met. DBHDS implemented and documented that it adequately fulfilled the data sets' reliability and validity requirements. The Health, Safety and Well Being, Community Inclusion/Integrated Settings, and Provider Competency and Capacity KPA workgroups all developed, initiated and monitored performance measures with set targets or goals. These measures were selected from the lists specified in the applicable Indicator. Each workgroup also finalized surveillance data to be collected.

Provision V.D.4.

For Provision V.D.4.'s sole Indicator 38.1, this Twenty-third Period review confirmed that DBHDS met its requirements for the first time to collect data from each of the sources specified. The Department also completed a source system review or update for 16 data sources.

See Appendix K for the consultants' full report.

**Conclusion**

Regarding Provision V.B.'s 23 remaining Compliance Indicators, namely 29.1, 29.2, 29.4, 29.8, 29.10, 29.13, 29.14, 29.16–29.30 and 29.33, the Commonwealth has met the requirements of four of them (29.2, 29.4, 29.19 and 29.27) twice consecutively, and has moved another nine Indicators (29.1, 29.8, 29.10, 29.14, 29.26, 29.28–29.30 and 29.33) from conditionally met to fully met. Virginia has achieved an additional two Indicators, 29.23 and 29.25, for the first time. However, the Commonwealth did not meet eight Indicators, 29.13, 29.16–29.18, 29.20–29.22 and 29.24, and therefore remains in Non-Compliance with this Provision.

Regarding Provision V.C.1.'s four remaining Compliance Indicators, namely 30.4, 30.7, 30.10 and 30.11, Virginia has met the requirements of two of them, 30.7 and 30.11, twice consecutively. However, the Commonwealth did not achieve the other two Indicators, 30.4 and 30.10, and therefore remains in Non-Compliance with this Provision.

Regarding Provision V.C.4.'s remaining three Compliance Indicators, namely 32.3, 32.4 and 32.7, Virginia has met the requirements of one of them, 32.3, twice consecutively, and has achieved the other two Indicators, 32.4 and 32.7, for the first time. Therefore, the Commonwealth has achieved Compliance with this Provision for the first time.

Regarding Provision V.D.1's remaining six Compliance Indicators, namely 35.1, 35.3 and 35.5–35.8, Virginia has met the requirements of one of them, 35.6, twice consecutively. However, the Commonwealth did not achieve the other five Indicators, 35.1, 35.3, 35.5, 35.7 and 35.8, and therefore remains in Non-Compliance with this Provision.

Regarding Provision V.D.2.'s eight Compliance Indicators, namely 36.1–36.8, Virginia has met the requirements of one of them, 36.5, twice consecutively, and moved another four Indicators (36.2, 36.4, 36.6 and 36.7) from conditionally met to fully met. The Commonwealth has achieved the requirements of an additional two Indicators, 36.1 and 36.3, for the first time. Virginia did not meet one remaining Indicator, 36.8, and therefore remains in Non-Compliance with this Provision.

Regarding Provision V.D.3's remaining 14 Compliance Indicators, namely 37.1, 37.2, 37.5–37.7, 37.10, 37.12, 37.14, 37.16–37.18, 37.20, 37.22 and 37.24, the Commonwealth has achieved the requirements of one of them, 37.17, twice consecutively, and moved another 12

Indicators, 37.1, 37.2, 37.5, 37.6, 37.10, 37.12, 37.14, 37.16, 37.18, 37.20, 37.22 and 37.24, from conditionally met to fully met. Virginia has met an additional Indicator, 37.7, for the first time, and therefore has achieved this Provision for the first time.

Regarding Provision V.D.4's sole Compliance Indicator 38.1, the Commonwealth has met its requirements for the first time, and therefore has achieved this Provision for the first time.

## *9. Provider Training*

**Background**

A review of the Agreement's two Provisions related to Provider Training, namely V.H.1. and V.H.2., was last conducted as part of the Twenty-first Period Report. This study determined that Virginia had sustained achievement of nine of the 13 Indicators associated with Provision V.H.1., but that four Indicators, namely 49.2–4 and 49.12, had remained unmet. The Commonwealth had again maintained Sustained Compliance with Provision V.H.2.

The Twenty-first Period review found that Virginia had furthered its progress toward a fully functioning statewide core competency-based training curriculum. This included:

- Providing reliable oversight of provider implementation to ensure that Direct Support Professionals (DSPs) and their supervisors were competent in the elements of each Individual Supports Plan (ISP) for which they were responsible.
- Ensuring that provider staff were trained in the knowledge and performance competencies required to carry out their job responsibilities; and,
- Providing training and technical support to service providers across a variety of areas.

The Commonwealth had also made a significant change in its monitoring methodology. DBHDS had incorporated oversight of providers' implementation of the statewide core curriculum into its QSR process. This included designing a specific assessment approach for its annual QSR evaluation of providers.

In June 2022, DBHDS's aggregate QSR report had included its first complete set of data that showed improvements over Virginia's previous monitoring methodology. Although this data set was available for analysis, the Department had not yet determined how to reliably calculate the

required quotients that would show the extent to which it had achieved the performance measures required by Indicators 49.2–4. For example, the QSR process 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, the Commonwealth could not generalize its findings and report these data for compliance determinations.

DBHDS's Office of Licensing (OL) had continued to carry out Indicator 49.12's requirements through its annual inspections of providers. OL had delivered provider-specific scoring for all licensed providers, but the Department was not able to verify that its data sets documenting these activities and results were reliable and valid.

**Twenty-third Period Study**

For this latest review, the Independent Reviewer retained the same consultant as previously to assess whether sufficient evidence existed to determine if Virginia has achieved each of Provision V.H.1.'s four remaining Indicators, 49.2, 49.3, 49.4 and 49.12.

Indicators 49.2–4 specify respectively that the Commonwealth must require DSP and DSP supervisors to meet detailed training and pass core competency requirements contained in DMAS regulations, that DSPs who have not yet completed the required training and passed a knowledge-based test are accompanied and overseen by other qualified staff, and that at least 95% of DSPs and their supervisors receive the required training and core competency testing. Indicator 49.12 requires that at least 86% of licensed providers receiving an annual inspection have a training policy that meets DBHDS requirements for staff training and provides support to carry out their job responsibilities.

Related to Indicators 49.2–4 and to address data verification and reliability issues, DBHDS provided for review a detailed description of the verification, validation and testing of its revised QSR process. This latest study found that the Department had improved its data gathering processes, and verified that its QSR Round 5 produced reliable and valid data related to provider training. In response to concerns in the prior review regarding the generalizability of the QSR sample, DBHDS worked with the QSR vendor and documented that DSPs were now randomly selected, and that the number reviewed was a statistically significant sample.

This Period's study verified Virginia's documentation that showed it achieved Indicators 49.2 and 49.3 for the first time during the Twenty-second Period, and sustained this achievement through the Twenty-third Period.

However, the Commonwealth's newly reliable and valid data sets documented that it did not meet Indicator 49.4's performance measures that at least 95% of DSPs and their supervisors receive the required orientation and training, as well as competency training. DBHDS reported that its QSR Round 5 process determined that 77.8% of providers met the orientation and training requirements, and that 85.3% met the competency training requirements.

The Twenty-third Period review reconfirmed that DBHDS maintained achievement of Indicator 49.12's particular stipulation that licensed providers fulfill the training policy requirements. In addition, the Department's licensing requirements prescribe sanctions that it can apply against providers with significant or re-occurring citations.

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Additionally, this Period's study verified that DBHDS's data processes related to Indicator 49.12 were well documented. A Department data analyst tested steps in each of the processes, and determined that they were accurately described and that the resulting data were reliable and valid. However, these newly reliable and valid data sets showed that the Department did not achieve Indicator 49.12's 86% benchmark. Of the applicable two regulatory requirements, OL's annual inspections determined that only 84.17% and 76.33% of providers complied as required.

See Appendix J for the consultant's full report.

**Conclusion**

Regarding Provision V.H.1's remaining four Compliance Indicators, namely 49.2–49.4 and 49.12, Virginia met the requirements of two of them, 49.2 and 49.3, for the first time during the Twenty-second Period, and achieved these same two Indicators twice consecutively for the Twenty-third Period. The Commonwealth did not meet the requirements for the other two Indicators, 49.4 and 49.12. Therefore, Virginia remained in Non-Compliance with this Provision.

## *10. Quality Improvement Programs*

**Background**

As of the Twenty-first Period, three Provisions, V.E.1.–V.E.3., and their associated 11 Indicators specified the Agreement's requirements for Quality Improvement (QI) Programs.

The Twenty-first Period review determined that, for Provision V.E.1.'s five Indicators (42.1–42.5), the Commonwealth had again met two of them, 42.1 and 42.2, and had also met 42.5 for the first time. However, Virginia had not met the remaining two, 42.3 and 42.4, and so remained in Non-Compliance.

Of Provision V.E.2.'s four Indicators, 43.1–43.4, the Commonwealth had once again not met any of them, and remained in Non-Compliance.

Regarding Provision V.E.3.'s two Indicators, 44.1–44.2, Virginia had again not met one of them, 44.1, but had conditionally met the other, 44.2, and so remained in Non-Compliance.

For Provision V.E.1., DBHDS had reported that 83% of providers had been assessed for compliance in 2021, and 84% had been assessed during the first six months of 2022, falling just short of Indicator 42.3's required 86% benchmark. During these same time periods, the Department had reported that only 52% and 54% respectively of providers had been compliant, falling well below Indicator 42.4.'s 86% performance measure. Also, DBHDS had not provided evidence that non-compliant providers had implemented the required Corrective Action Plans (CAPs). However, for the first time, the Department had fulfilled the requirements of Indicator 42.5 by providing the necessary documentation, and showing that Training Centers' QI programs had performed functions consistent with this Indicator's specifications.

Regarding Provision V.E.2., the Twenty-first Period study had found that DBHDS had not fulfilled the measures of two Indicators, 43.1 and 43.2, and had not determined that its QSR data sets related to these Indicators were reliable and valid. For Indicator 43.3, the Department had not submitted evidence that it had completed the required analysis of the community integration measure derived from the QSR data, and had again not verified the validity and reliability of the relevant data sets. DBHDS had made progress toward achieving Indicator 43.4's requirements by defining provider reporting measures across all required domains. However, the Department had not reviewed or analyzed its recent serious incident data.

In July 2023, the Parties had agreed, and the Court had ordered that one of this Provision's Indicators, namely 43.2, be removed from the Consent Decree.

For Provision V.E.3.'s Indicator 44.1, although DBHDS had submitted the required QSR Provider Quality Review (PQR) tool, the Twenty-first Period review had found that the tool's

questions, evaluation criteria and additional guidelines were not sufficient for assessing and determining the adequacy of providers' QI programs, as required. Regarding Indicator 44.2, the Department had implemented a pilot project to collect data from the Office of Licensing (OL) reviews that had identified DD providers with an approved Corrective Action Plan (CAP). In addition, DBHDS's QSR contractor had issued QI plans that included basic steps for the providers to take to address the identified deficiencies. However, since the Department had not verified the validity and reliability of its QSR data sets, the Commonwealth had met this Indicator only conditionally. Such conditional ratings are not yet final and cannot be used for Compliance determinations, but rather are for illustrative purposes only.

**Twenty-third Period Study**

For the latest review, the Independent Reviewer retained the same consultants to assess the status of Virginia's achievement of the three QI Programs Provisions, V.E.1.–V.E.3., which had not yet been determined to be in Compliance. This study focused on a total of eight Indicators (42.3–5, 43.1, 43.3–43.4 and 44.1–44.2) that had remained unmet, either at all or fully, or had not been achieved twice consecutively. This followed the July 2023 Court Order to remove Indicator 43.2.

The latest review found that for Provision V.E.1., DBHDS demonstrated that at least 86% of its licensed providers of DD services have been assessed for their compliance with the applicable regulations during their annual inspections, resulting in the Commonwealth meeting Indicator 42.3's requirements for the first time. However, for each of the past four reported quarters, the Department still did not achieve Indicator 42.4's 86% benchmark for its licensed providers to comply with these same regulations. Virginia continued to meet Indicator 42.5's requirements that DBHDS's Training Centers have QI programs in place.

This Period's study determined that the Commonwealth met the requirements of each of Provision V.E.2.'s three remaining Indicators, 43.1, 43.3 and 43.4, for the first time. DBHDS continued to collect and report data for community integration, and for 12 surveillance measures related to negative aspects of health and safety that come from provider critical incident reporting. The Department also notified its DD providers of its expectations regarding provider risk management programs and related reporting measures. In addition, DBHDS supplied links to appropriate tools that specified the parameters for collecting this data. Overall, the Department's data collection and reporting adequately conformed to the Agreement's requirements.

Regarding Provision V.E.3., for the first time Virginia met Indicator 44.1's requirements to use the QSR process to assess providers' QI programs. DBHDS continued to use the PQR tool, which included six elements relevant to the determination of the adequacy of these programs. This latest study also found that the Department and its QSR vendor had sufficiently enhanced the guidance and evaluation criteria for use by QSR reviewers when making determinations.

On the other hand, this Period's review determined that the Commonwealth did not meet Indicator 44.2's requirements. Following a spot check by the consultants, the study could not confirm that any of 15 vendor-issued QI programs that the QSR reviewed sufficiently addressed the providers' QI deficiencies, or identified the needed remediation or the need for technical assistance. While the consultants' sample size was small, the finding was universal, and called the QSR data for this Indicator into question. The Independent Reviewer has previously identified concerns regarding the adequacy of DBHDS's QSR Inter-rater reliability process, and its potential threat to the validity and reliability of QSR data. The Department should further examine its related *Process Documents* and *Attestations* for this QSR data set to ensure it has adequately identified and addressed these concerns.

See Appendix K for the consultants' full report.

**Conclusion**

Regarding Provision V.E.1.'s remaining three Compliance Indicators, namely 42.3–42.5, Virginia has met one Indicator, 42.3, for the first time. The Commonwealth has also now achieved Indicator 42.5's requirements twice consecutively. However, Virginia has still not met Indicator 42.4, and therefore remains in Non-Compliance with this Provision.

Regarding Provision V.E.2.'s remaining three Compliance Indicators, namely 43.1, 43.3 and 43.4, the Commonwealth has met the requirements of all of them for the first time. Therefore, Virginia has achieved Compliance with this Provision for the first time.

Regarding Provision V.E.3.'s two Compliance Indicators, namely 44.1 and 44.2, the Commonwealth has met the requirements of one of them, 44.1, for the first time. However, Virginia has not met Indicator 44.2, and therefore remains in Non-Compliance with this Provision.

## *11. Mortality Reviews*

**Background**

The Twenty-first Period's review determined that the Commonwealth had again met 19 of the 21 Indicators associated with Provision V.C.5., 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 remained in Non-Compliance with this Provision.

For five of the six months of this Twenty-first Period, DBHDS's Mortality Review Committee's (MRC's) rate at which it had reviewed unexpected deaths within 90 days increased to 76.5%. Even though this represented an improvement over the prior Period, Virginia once again had not achieved the 86% measure required by both Indicators 33.13 and 33.15. The MRC had submitted quarterly reports to the Commissioner, as required, which included the necessary deliberations, findings and recommendations, and had noted when no recommendations were warranted. However, because these reports could not include the results of reviews for 86% of deaths (since the Committee's rate had been just 76.5%), Indicator 33.15 had remained unmet.

The study of Indicators 33.13 and 33.15 had verified that DBHDS's *Process Document* and *Attestation* related to mortality reviews were complete. They had accurately described the data intended to be collected by the MRC and the data collection process, as well as the steps taken by the Department's data analyst to ensure the reliability and validity of these data sets. The consultant had conducted spot checks that verified the accuracy and reliability of the data that the Commonwealth had reported for this study.

**Twenty-third Period Study**

For the latest review, the Independent Reviewer retained the same consultant to assess the status of Virginia's achievement of Mortality Reviews Provision V.C.5., which had not yet been determined to be in Compliance. The consultant's study focused on the two remaining Indicators (33.13 and 33.15), which had not been previously met, and included both the Twenty-second and Twenty-third Periods.

Regarding Indicator 33.13, the consultant found that, for the Twenty-second Period, the MRC completed 94% of the reviews of unexpected deaths within 90 days during the final five months of the Period, i.e., November 2022 through March 2023. This 94% calculation excluded October 2022, when the MRC's reviews had focused on seven deaths that had occurred outside of the required 90 days, in order to catch up on its reviews of all deaths. Even though the 86%

benchmark was not met for October 2022, it is the Independent Reviewer's considered opinion that the MRC overall achieved the intent of this performance measure for the Twenty-second Period, and so the Commonwealth met the requirements of Indicator 33.13.

For the Twenty-third Period, the consultant verified that the MRC completed 86% of its reviews of unexpected deaths within the required 90-day timeframe. Virginia therefore met Indicator 33.13 for this Period as well.

Regarding Indicator 33.15, the MRC's quarterly reports to the Commissioner are submitted within 90 days after each quarter ends. Given the two Periods being studied for this latest review, only three quarterly reports were available and expected for this study. The fourth quarterly report will be submitted in December 2023.

The consultant confirmed that the MRC did complete and submit the required three quarterly reports to the Commissioner for the Twenty-second Period and the first half of the Twenty-third Period. Each of these reports included the necessary deliberations, findings and recommendations. They also stated affirmatively when the MRC determined that no recommendations were warranted.

For the three quarters overall, the MRC's reports detailed the Committee's findings for 88% of unexpected deaths within 90 days. For each of the first two quarters (i.e., for the Twenty-second Period), the MRC reviewed 94% of the unexpected deaths within 90 days. For the third quarter (i.e., the first half of the Twenty-third Period), the MRC included reviews of six older deaths and, overall, there were fewer unexpected deaths. This combination reduced the rate for the third quarter to 77%, i.e., below the Indicator's benchmark performance measure of 86%.

It is the Independent Reviewer's considered opinion, however, that the Commonwealth did meet the intended purpose of the 86% performance measure for the combined three quarters. The goal of the Agreement is that Virginia achieves the performance metric over the term of the review periods in question, rather than for each individual quarter. The MRC's overall completion rate of 88% for the three quarters reflects the durability of DBHDS's current systems and processes that ensure the MRC completes at minimum the benchmark percentage of reviews of unexpected deaths within 90 days. Because the MRC submitted three consecutive quarterly reports with the required information for 88% of the unexpected deaths, the Commonwealth achieved the intended purpose of and met Indicator 33.15 for the Twenty-third Period.

This study also verified that DBHDS once again completed the data reliability and validity requirements for the reported data sets related to mortality reviews of unexpected deaths for Indicators 33.13 and 33.15.

See Appendix H for the consultant's full report.

**Conclusion**

Regarding Provision V.C.5's remaining two Compliance Indicators, namely 33.13 and 33.15, Virginia has met the requirements of Indicator 33.13 for the Twenty-second Period. For the Twenty-third Period, the Commonwealth again met Indicator 33.13 and Indicator 33.15. Therefore, the Commonwealth has achieved Compliance with this Provision for the first time.

## *12. Office of Licensing and Office of Human Rights*

**Background**

As a result of the Twenty-first Period review, Virginia had sustained Compliance with four of the six Provisions, namely V.C.2., V.C.3., V.G.1. and V.G.2, related to the Office of Licensing (OL) and Office of Human Rights (OHR). The Commonwealth had also fully achieved Compliance with Provision V.G.3.'s four Indicators (48.1–48.4) for the first time. In addition, the study had verified that Virginia had achieved five of Provision V.C.6.'s eight associated Indicators (34.1–34.3 and 34.6–34.7) twice consecutively. A further three Indicators (34.4, 34.5 and 34.8) had been met conditionally and for illustrative purposes only.

DBHDS had exceeded Indicator 34.4's required 86% benchmark by reporting that 97% of incidents had been reported within its expected timeline. In addition, OL and OHR had systematically improved their tracking of agencies for late incident reporting and Corrective Action Plans (CAPs), which had achieved the requirements of Indicator 34.5. For Indicator 34.8, the Department had the required policies and processes in place that specify requirements for Training Centers to report serious incidents and to implement and monitor corrective actions. OHR had reviewed these reported incidents monthly and annually to determine if identified causes had been addressed.

However, since DBHDS's reported data sets were not verified as reliable and valid, the Commonwealth had only achieved these Indicators conditionally.

**Twenty-third Period Review**

For this latest study, the Independent Reviewer retained a consultant experienced with the Agreement to assess whether Virginia has fully achieved the three remaining OL and OHR Indicators (34.4, 34.5 and 34.8), which had only been conditionally met the year before. At that time, the documentation of the required processes was not fully detailed and the reliability and validity of the data resulting from them had not been sufficiently validated.

Since then, DBHDS conducted an extensive review of these processes. The Department developed detailed descriptions for each of the processes, and conducted data verification procedures to attest that the data sets resulting from these processes were reliable and valid. The Risk Management Review Committee (RMRC) is responsible for the oversight of these processes, the ongoing review of data and information coming from them, and for recommending process improvements and corrective actions necessary to assure their ongoing viability. Based on the latest study of these *Process Documents*, and a comparison of the descriptions with relevant OL and OHR regulations, Virginia statutes, and *Departmental Instructions*, the consultant verified that the processes required by these three Indicators were established, well-documented, operational, and producing valid and reliable data. From this data, DBHDS can now draw relevant conclusions and make objectively informed process revisions and improvements.

In addition, the consultant verified that the Commonwealth once again met the requirements and exceeded the performance measures of these three Indicators.

See Appendix I for the consultant's full report.

**Conclusion**

Regarding Provision V.C.6.'s remaining three Compliance Indicators, namely 34.4, 34.5 and 34.8, Virginia has fully met the requirements of all of them. Therefore, the Commonwealth has achieved Compliance with this Provision for the first time.

## *13. Regional Quality Councils*

**Background**

Two Provisions, V.D.5. and V.D.5.b., and their associated 12 Compliance Indicators specify the Agreement's requirements for Regional Quality Councils (RQCs).

Of Provision V.D.5.'s five Indicators, the Twenty-first Period study concluded that Virginia had continued to meet three of them, namely 39.1–39.3. Another two Indicators, 39.4 and 39.5, had been achieved for the first time, but only conditionally. Therefore, the Commonwealth had remained in Non-Compliance.

Of Provision V.D.5.b.'s seven Indicators, the same review determined that Virginia had continued to meet four of them, namely 40.1, 40.3, 40.4 and 40.6. Another Indicator, 40.7, had been achieved for the first time. The two remaining Indicators, 40.2 and 40.5, had been met conditionally, so the Commonwealth had remained in Non-Compliance with this Provision as well.

The determination of conditionally met for four RQC Indicators was due to Virginia's data not being verified as reliable and valid. These ratings were not yet final and could not be used for compliance determinations, but were for illustrative purposes only.

To conditionally achieve Provision V.D.5.'s Indicators 39.4 and 39.5 for the first time, DBHDS had organized the presentation of relevant data reports for review by RQC members. The Department had provided the RQCs with comparisons of current data with that from previous quarters, allowing Council members to easily visualize trends over time and, as a result, formulate questions and requests for additional information. The RQCs used DBHDS's toolkits to develop their proposed quality improvement initiatives (QIIs) and to include measurable objectives that had been lacking previously.

Regarding Provision V.D.5.b.'s Indicator 40.2, the RQC's meeting minutes had reflected the required review and evaluation of data, trends and monitoring efforts. Each RQC had submitted at least one QII recommendation to DBHDS's Quality Improvement Committee (QIC). Once again, however, the Department had not yet determined that its relevant data sets were reliable and valid, so the Indicator was only conditionally met.

The Twenty-first study determined that the Commonwealth had also only conditionally met Indicator 40.5. DBHDS had fulfilled the requirement that each RQC develop at least one QII with a measurable outcome, but again the data sets utilized by the RQCs were not verified as valid and reliable.

Virginia had met the requirements of Indicator 40.7 for the first time. The RQCs had reported to the QIC on their monitoring and analysis of the statewide and regional impact of QIIs. When the QIC had declined to support a recommended QII, the Committee had responded to the respective RQC with the reason for that determination.

**Twenty-third Period Study**

For this latest review, the Independent Reviewer retained the same consultants as before to assess the status of the Commonwealth's achievement of the two RQC Provisions, V.D.5. and V.D.5.b., which had not yet been determined to be in Compliance. The study focused on five remaining Indicators, 39.4, 39.5, 40.2, 40.5 and 40.7, four of which had not been fully achieved previously, and one of which had not been met twice consecutively.

The Twenty-third Period study of RQC minutes and materials for the four quarters since the last review determined that Virginia had fully achieved Provision V.D.5.'s Indicators 39.4 and 39.5.

Regarding Provision V.D.5.b.'s Indicator 40.2, the study again found that minutes of RQC meetings reflected the review and evaluation of data, trends and monitoring efforts. Each RQC again submitted at least one QII recommendation to the QIC. For Indicator 40.5, findings were consistent with the previous report. Each RQC again recommended a QII with at least one proposed measurable outcome.

For this Twenty-third Period review, DBHDS conducted data source system assessments, and provided more comprehensive *Process Documents* and *Attestations* that addressed the identified threats to its data validity and reliability, as well as the adequacy of its mitigation strategies. Due to the Department's substantial improvement in ensuring data validity and reliability related to Indicators 39.4, 39.5, 40.2 and 40.5, the Commonwealth fully met these Indicators' requirements for the first time.

Regarding Indicator 40.7, Virginia achieved all its requirements for a second consecutive period.

See Appendix K for the consultants' full report.

**Conclusion**

Regarding Provision V.D.5.'s remaining two Compliance Indicators, namely 39.4 and 39.5, the Commonwealth has fully met the requirements of both of them for the first time. Therefore, Virginia has achieved Compliance with this Provision for the first time.

Regarding Provision V.D.5.b.'s remaining three Compliance Indicators, namely 40.2, 40.5 and 40.7, the Commonwealth has fully met the requirements for two Indicators, 40.2 and 40.5, for the first time. Virginia has now met the third Indicator, 40.7, twice consecutively. Therefore, the Commonwealth has achieved Compliance with this Provision for the first time.

## *14. Public Reporting*

**Background**

Two Provisions, V.D.6. and IX.C., and their associated nine Indicators specify the Agreement's requirements for Public Reporting.

Of Provision V.D.6.'s five Indicators, namely 41.1–41.5, the Twenty-first Period review had determined that the Commonwealth had conditionally met four of them, 41.1–41.4. Virginia had not achieved the remaining Indicator 41.5, and so had continued in Non-Compliance with this Provision.

Of Provision IX.C.'s four Indicators, namely 54.1–54.4, the Commonwealth had not met any of them, and therefore also remained in Non-Compliance.

Regarding Provision V.D.6. during this Period, DBHDS had posted its *Provider Data Summary Semi-Annual Report State Fiscal Year 2021.* This report 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, as required by Indicators 41.1–41.3. The Department had also posted its latest *Developmental Disabilities Quality Management Plan State Fiscal Year 2021*, which included information on all the topics defined in Indicator 41.4. However, because DBHDS had not found that its data sets related to these four Indicators were reliable and valid, this resulted in a determination for these four Indicators of conditionally met. Such ratings are not yet final and cannot be used for Compliance determinations, but rather are for illustrative purposes only.

For Indicator 41.5, DBHDS had not submitted the required additional or updated documentation on the Record Index (a.k.a. the Library site) and had not indicated whether its *DOJ Settlement Agreement Library Protocol* remained current.

In general, regarding Provision IX.C.'s four Indicators (54.1–54.4), Virginia had not provided the required documentation on its Library site. For Indicators 54.1 and 54.2, DBHDS had not supplied any additional protocols or updates for review of its *Settlement Agreement Library Record Index* or its *DOJ Settlement Agreement Library Protocol*. In addition, as specified in Indicators 54.3 and 54.4, the Department had not posted any related documents or updates for review, and did not maintain its Library site in accordance with the applicable *Library of Virginia Records Retention and Disposition Schedules*.

**Twenty-third Period Study**

For the latest review, the Independent Reviewer retained the same consultants as before to assess the status of the Commonwealth's achievement of the two Public Reporting Provisions, V.D.6. and IX.C., which had not yet been determined to be in Compliance. Their total of nine associated Indicators had not been achieved previously, either fully or at all.

For this Period's study regarding Provision V.D.6., DBHDS provided a *Provider Data Summary Semi-Annual Report State Fiscal Year 2023, May 2023*. As required by Indicator 41.1, this again 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 such strategies. The report also provided the demographics required by Indicators 41.2. and 41.3. For the Period, the Department issued a *Developmental Disabilities Annual Report and Evaluation State Fiscal Year 2022*. This most recent version again included information on all the topics specified in Indicator 41.4. Additionally, the consultant verified that DBHDS had posted the information required by Indicator 41.5 on the Library site or on the Department's website.

DBHDS provided its relevant *Process Document* that detailed the process used to confirm the validity and reliability of the Department's reported data sets related to Indicators 41.1–41.5. The Twenty-third Period review verified that this document was sufficient to validate the reported data, and so Virginia fully met these five Indicators.

Regarding Provision IX.C. and its four associated Indicators (54.1–54.4), DBHDS undertook a multi-phase project to assess the Library and make improvements. For the Twenty-third Period review, the Department provided a document with links to the specific pages of its Library site for most of the reports and information required by these Indicators. Without the benefit of the links, it would have been difficult to locate pertinent documents. For example, a *Record Index Reference Tool* is available on the Library site, but the site does not feature a tab on its Welcome

page to access this tool, or to clearly indicate that it exists. While the Library site is well constructed and includes a wealth of information, many stakeholder and public users would likely find it unnecessarily challenging to navigate and access the desired information. Further improvements are needed for stakeholders and the public to readily find what they are seeking.

The *Record Index Reference Tool* is available on the Library site's Record Index page. In addition to developing this tool, DBHDS created a *Process Document* that provides a glossary of terms and describes roles and responsibilities for ensuring that the *Record Index Reference Tool* and the primary webpages specific to the Agreement are updated at least semiannually and that the various reports are updated according to their due dates. As required by Indicators 54.1–54.3, the latest study confirmed that for 42 distinct reports, the *Record Index Reference Tool* specifies the parent page, the frequency and the due date for each report to be posted to the Library. The Record Index and all associated documents are timely available to the Independent Reviewer upon request.

For this Twenty-third Period review, the Commonwealth met the criteria for Indicator 54.4. Its *Process Document's* Glossary of Terms/Roles and Responsibilities clearly states that under the Code of Virginia, the Library of Virginia (LVA) has the authority to issue regulations governing the retention and disposition of state and local public records. In keeping with the Code's mandate, LVA has developed records retention and disposition schedules outlining the disposition of public records. The retention schedule for documents on the Agreement's Library site is ten years.

See Appendices L for the consultants' full reports.

**Conclusion**

Regarding Provision V.D.6.'s five Compliance Indicators, namely 41.1–41.5, Virginia has fully met the requirements of all of them. Therefore, the Commonwealth has achieved Compliance with this Provision for the first time.

Regarding Provision IX.C.'s four Compliance Indicators, namely 54.1–54.4, Virginia has met the requirements of all of them. Therefore, the Commonwealth has achieved Compliance with this Provision for the first time.

# III. CONCLUSION

During the Twenty-third 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.

Of the 131 Compliance Indicators studied this time, the Commonwealth had previously met 71, either fully or conditionally. As a result of the Twenty-Third Period reviews, Virginia achieved an additional 33 Indicators for the first time, but did not fulfill another four Indicators that had been met before. In total, the Commonwealth has now achieved the requirements of 100 of the 131 outstanding Indicators, resulting in coming into Compliance with 15 Provisions for the first time. In doing so, Virginia has adequately addressed data reliability and validity concerns with these 100 Indicators.

The newly fulfilled Provisions reflect accomplishments across many service, monitoring, reporting, and quality and risk management areas of the Consent Decree. The remaining 31 Indicators that the Commonwealth has not yet met at all, despite some improvements, include critically important outcomes for the individuals at the heart of the Agreement. These Indicators include the receipt of needed services and in-home crisis assessments, the adequate and appropriate delivery of behavioral services, the sufficiency of needed nursing services, increased participation in day services in integrated settings, and the adequate training and competency of support staff.

A total of 60 Indicators across 25 Provisions still remain to be achieved, either for the first time or twice consecutively.

Throughout this Twenty-third 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 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 individuals with IDD and their families.

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

# IV. RECOMMENDATIONS

The Independent Reviewer recommends that the Commonwealth undertake the seven actions listed below, and provide a report that addresses these recommendations and their status of implementation by March 31, 2024. Virginia should also consider the additional recommendations and suggestions included in the consultants' reports, which are contained in the Appendices.

**Individual and Family Support Program and Family-to-Family and Peer Programs**

1. DBHDS and the contracted family-to-family and peer mentoring program providers should track outcomes related to individuals and their families who are considering sponsored homes or congregate residential settings.

**Crisis and Behavioral Services**

2. DBHDS should complete a root cause analysis and implement a plan to address and resolve the obstacles to conducting 86% of initial crisis assessments in the homes of individuals in crisis or in other community locations where the crisis occurs.

3. DBHDS should work with its REACH programs to develop and implement a plan to address the staffing shortages in its statewide crisis services system.

**Transportation**

4. DBHDS should work with its Quality Service Reviews (QSR) vendor to reduce the number of 'Could Not Determine (CND)' responses regarding reliable transportation. The percentage of CND responses should be tracked over time to ensure that process improvement efforts achieve the desired reduction.

**Community Living Options**

5. DBHDS should develop and implement a new approach to calculating verifiable nursing utilization rates. The method should determine the extent to which the needed number of nursing hours, as identified in Individual Supports Plans (ISPs), is actually delivered to individuals with IDD.

**Quality Improvement Programs**

6. DBHDS should examine and take needed steps to resolve previously identified data integrity threats regarding the QSR inter-rater reliability process.

**Public Reporting**

7. The Commonwealth should improve its Library site navigation so that stakeholders and the public can access high-level summary trends and more easily find specific reports or information.

# 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 23rd Period are not in bold.<br><br>Ratings for the 23rd Period are in **bold.**<br><br>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.<br><br>The Findings Section and attached consultant reports include explanatory information regarding the Compliance Indicators.<br><br>*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.*<br>*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<br>**Compliance** | Of the remaining nine Compliance Indicators, the Commonwealth met all of them 1.1–1.4, 1.6, 1.7, 1.9–1.11 and achieved Compliance for the first time. |

| 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** | Of the six remaining Compliance Indicators, Virginia met five, namely, 2.2, 2.3, 2.5, 2.18 and 2.20, but did not meet 2.16 and therefore remains in Non-Compliance. |
| **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. | Compliance<br><br>Sustained Compliance | *The Commonwealth has met all six Compliance Indicators, 6.1a, 6.1b, 6.1, 6.2, 6.3, and 6.4. Virginia has achieved Sustained Compliance.* |
| **III.C.6.a.i.-iii.** | The Commonwealth shall develop a statewide crisis system for individuals with intellectual and developmental disabilities. The crisis system shall:<br>i. Provide timely and accessible support …<br>ii. Provide services focused on crisis prevention and proactive planning …<br>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<br><br>**Non Compliance** | Of the remaining five Compliance Indicators, the Commonwealth met three of them 7.14, 7.19 and 7.20, but did not meet 7.8 and 7.18 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 **Compliance** | Of the remaining one Compliance Indicator, the Commonwealth met Indicator 8.4 and achieved Compliance for the first time. |
| **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–22nd 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<br><br>**Non Compliance** | Of the remaining one Compliance Indicator, the Commonwealth did not achieve 10.4. and therefore remains in Non-Compliance. |
| **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 | The Commonwealth did not meet the sole indicator 11.1, and therefore remains in Non |

| Settlement Agreement Reference | Provision | Compliance Rating | Comments |
|---|---|---|---|
| | | **Non Compliance** | 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<br>**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<br>**Non Compliance** | Of the remaining one Compliance Indicator, the Commonwealth did not achieve 13.3 and therefore is in Non 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<br>**Non Compliance** | Of the remaining three Compliance Indicators, the Commonwealth did not achieve 14.8–14.10 and therefore remains in Non-Compliance.<br>The Court removed Indicators 14.2-14.7** |

| 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<br><br>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. | Compliance **Sustained Compliance** | Of the remaining two Compliance Indicators, the Commonwealth met both 16.2 and 16.8 in both the 22nd and 23rd Periods and therefore has achieved Sustained Compliance for the first time. |
| **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 | Sustained Compliance | *The Commonwealth again met the two Compliance Indicators 17.1 and 17.2 and therefore has Sustained Compliance.* |
| **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** | Of the remaining six Compliance Indicators, the Commonwealth met five of them, 18.2–18.6, but did not meet Indicator 18.9 and therefore remains in Non-Compliance. |

| Settlement Agreement Reference | Provision | Compliance Rating | Comments |
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| **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 1,872 individuals who are now living in their own homes. This is 1,531 more individuals than the 341 individuals who were living in their own homes as of 7/1/15.* |
| **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 |
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| **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 **Compliance** | The Commonwealth met all three Compliance Indicators 19.1–19.3 and therefore achieved Compliance for the first time. |
| **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 **Removed**** | The Court removed Indicators 20.1-20.13** . |
| **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 |
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| **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 |
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| **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 |
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| **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 |
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| **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 |
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| **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 |
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| **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.*<br>*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.*<br>*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 |
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| **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.*<br><br>*The Independent Reviewer's Individual Services Review studies found that PMM visits occurred. The monitors had been trained and utilized monitoring checklists.*<br><br>*Interviews and documents reviewed indicate that this process remains in place at SEVTC.* |

| Settlement Agreement Reference | Provision | Compliance Rating | Comments |
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| **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.*<br>*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.*<br>*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.*<br>*Interviews and documents reviewed indicate that this process remains in place at SEVTC.* |

| Settlement Agreement Reference | Provision | Compliance Rating | Comments |
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| **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.*<br>*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.*<br>*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.*<br>*Interviews and documents reviewed indicate that this process remains in place at SEVTC.* |

| Settlement Agreement Reference | Provision | Compliance Rating | Comments |
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| **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 23rd Period are <u>not</u> in bold.<br><br>Ratings for the 23rd Period are in **bold.**<br><br>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.<br><br>The Findings Section and attached consultant reports include additional explanatory information regarding the Compliance Indicators.<br><br>*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 |
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| **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<br><br>**Non Compliance** | Of the remaining 23 Compliance Indicators, the Commonwealth met fifteen (29.1. 29.2, 29.4, 29.8, 29.10, 29.14, 29.19, 29.23, 29.25-29.30 and 29.33), but did not meet eight (29.13, 29.16–29.18, 29.20–29.22 and 29.24). |
| **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<br><br>**Non Compliance** | Of the remaining four Compliance Indicators, the Commonwealth met two (30.7 and 30.11), but did not meet two (30.4 and 30.10) and remains in Non-Compliance. |
| **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<br><br>**Compliance** | Of the remaining 3 Compliance Indicators, the Commonwealth met all three (32.3, 32.4, and 32.7) and achieved Compliance for the first time. |
| **V.C.5.** | The Commonwealth shall conduct monthly mortality reviews for unexplained or unexpected deaths reported through its | Non Compliance | Of the remaining 2 Compliance Indicators, the Commonwealth met both of them (33.13-33.15) and |

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| | 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. | **Compliance** | achieved Compliance for the first time. |
| **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<br><br>**Compliance** | The Commonwealth has met all eight Compliance Indicators 34.1–34.8 and has achieved Compliance for the first time. |
| **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<br><br>**Non Compliance** | Of the remaining six Compliance Indicators, the Commonwealth has met one (35.6), but has not met five (35.1, 35.3, 35.5, 35.7 and 35.8) and therefore remains in Non-Compliance. |

| Settlement Agreement Reference | Provision | Compliance Rating | Comments |
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| **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. | Non Compliance<br>**Non Compliance** | Of the remaining eight Compliance Indicators, the Commonwealth has met seven (36.1–36.7), but has not met one (36.8) and therefore remains in Non-Compliance. |
| **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<br>**Compliance** | Of the remaining fourteen Compliance Indicators, the Commonwealth has met all of them (37.1, 37.2, 37.5–37.7, 37.10, 37.12, 37.14, 37.16–37.18, 37.20, 37.22), and has achieved Compliance for the first time. |
| **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<br>**Compliance** | The Commonwealth has met the sole Compliance Indicator 38.1 and achieved Compliance for the first time. |
| **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<br>**Compliance** | Of the remaining two Compliance Indicators, the Commonwealth met both of them (39.4-39.5) and achieved Compliance for the first time. |

| Settlement Agreement Reference | Provision | Compliance Rating | Comments |
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| **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 **Compliance** | Of the remaining three Compliance Indicators, the Commonwealth has met all of them (40.2, 40.5 and 40.7) and has achieved Compliance for the first time. |
| **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 **Compliance** | The Commonwealth has met all five Indicators 41.1–41.5 and has achieved Compliance for the first time. |
| **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 42.1–42.3 and 42.5. Virginia has not met Indicator 42.4. and remains in Non-Compliance. |
| **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 **Compliance** | Of the remaining three Compliance Indicators 43.1, 43.3 and 43.4, the Commonwealth met all of them and has achieved Compliance for the first time. The Court removed Indicator 43.2.** |

| Settlement Agreement Reference | Provision | Compliance Rating | Comments |
|---|---|---|---|
| **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<br><br>**Non Compliance** | The Commonwealth has met Indicators 44.1, but has not met 44.2. Therefore, Virginia remains in Non-Compliance. |
| **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.* |
| **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<br><br>Non Compliance | *When Virginia achieves the Indicators for III.C.5.b.i., it also achieves 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%).* |

| Settlement Agreement Reference | Provision | Compliance Rating | Comments |
|---|---|---|---|
| **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<br><br>**Compliance** | The Commonwealth has met both Compliance Indicators 46.1 and 46.2, and therefore achieved Compliance for the first time. |
| **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<br><br>**Non Compliance** | The Commonwealth has not met the sole Compliance Indicator 47.1, 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.* |

| Settlement Agreement Reference | Provision | Compliance Rating | Comments |
|---|---|---|---|
| **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<br><br>Compliance | *The Commonwealth met all four Compliance Indicators 48.1, 48.2, 48.3 and 48.4.*<br><br>*The Commonwealth achieved Compliance for the first time.* |
| **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<br><br>**Non Compliance** | Of the remaining four Compliance Indicators, the Commonwealth met Indicators 49.2 and 49.3, but did not achieve 49.4 and 49.12. Therefore, Virginia remains in Non-Compliance |
| **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 | *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<br><br>**Removed**** | The Court removed Indicators 51.1–51.5** |
| **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<br><br>**Removed**** | The Court removed Indicators 51.1–51.5** |

| Settlement Agreement Reference | Provision | Compliance Rating | Comments |
|---|---|---|---|
| **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 **Removed**** | The Court removed Indicators 53.1–53.4** |
| **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.* |
| **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 23rd Period are in **bold.** | **Comment** |

| Settlement Agreement Reference | Provision | Compliance Rating | Comments |
|---|---|---|---|
| **IX.C.** | The Commonwealth shall maintain sufficient records to document that the requirements of this Agreement are being properly implemented … | Non Compliance<br><br>**Compliance** | The Commonwealth has met all four Compliance Indicators (54.1–54.4), and therefore achieved Compliance for the first time. |

Notes:
** The Parties recommended and the Court removed these Indicators from the Consent Decree on July 27, 2023.

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

# APPENDIX A

## Individual and Family Support Program
## and
## Family-to-Family and Peer Programs

**by**

**Rebecca Wright, MSW, LICSW**

# Individual and Family Support Program 23rd Period Study

The Settlement Agreement in U.S. v. Commonwealth of Virginia requires the Commonwealth to create an Individual and Family Support program (hereinafter IFSP) for individuals with ID/DD whom the Commonwealth determines to be the most at risk of institutionalization. The related provisions are as follows:

**Section II.D:** Individual and family supports are defined as a comprehensive and coordinated set of strategies that are designed to ensure that families who are assisting family members with intellectual or developmental disabilities ("ID/DD") or individuals with ID/DD who live independently have access to person-centered and family-centered resources, supports, services and other assistance. Individual and family supports are targeted to individuals not already receiving services under HCBS waivers, as defined in Section II.C. The family supports provided under this Agreement shall not supplant or in any way limit the availability of services provided through the Elderly or Disabled with Consumer Direction ("EDCD") waiver, Early and Periodic Screening, Diagnosis and Treatment ("EPSDT"), or similar programs.
**Section III.C.2**: The Commonwealth shall create an individual and family support program for individuals with ID/DD whom the Commonwealth determines to be most at risk of institutionalization...
**Section 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 services.
**Section 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.
**Section IV.B.9.b.** ...The Commonwealth shall develop family-to-family and peer programs to facilitate these opportunities.

The Parties (i.e., the Commonwealth of Virginia and the U.S. represented by DOJ) have jointly submitted to the Federal Court a complete set of compliance indicators for all provisions with which Virginia had not yet been found in compliance. The agreed upon compliance indicators were formally submitted on Tuesday, January 14, 2020.

The 22nd Report to the Court found the Commonwealth had met 14 of 17 CIs, including many for the first time. The following summarizes the compliance status of the Provisions and Compliance Indicators (CIs) at that time:

- Regarding Provision III.C.2.a.-i.'s 12 Indicators, the Commonwealth had met most of the requirements, namely 1.2 - 1.12. Virginia had not achieved one Indicators (i.e., 1.1)
- Regarding Provision III.C.8.b.'s two Indicators, the Commonwealth had met both of them: 17.1 and 17.2.
- Regarding Provision III.D.5.'s three Indicators, the Commonwealth met 19.1, but had not yet met 19.2–19.3.

For this 23rd Period review, the Parties agreed to target the Compliance Indicators that have not been Met twice consecutively in the two most recent reviews. The 23rd Period reviews of these CIs, which were also studied in the recently completed 22nd Period, will reflect the progress made since that time. The

following summarizes the compliance status, as of the time of the 22nd Period Report, of those Provisions and Compliance Indicators under review for this Period:

| Provision | CIs studied in the 23rd Period | Two most recent ratings (i.e., M, M* or NM) |
|---|---|---|
| III.C.2.a.-f. | 1.1 | NM-NM |
| | 1.2-1.4 | NM-M |
| | 1.6 & 1.7 | NM-M |
| | 1.9-1.11 | NM-M |
| III.D.5. | 19.1 | NM-M |
| | 19.2 & 19.3 | NM-NM |

**23rd Period Study Purpose and Methodology**

In April 2019, the Court directed the Commonwealth to develop a library of documents that would show the Court the source of Virginia's authority (i.e., its organizational structure, policies, action plans, implementation protocols, instructions/guidelines, applicable compliance monitoring forms, sources of and actual data, quarterly reports, etc.) needed to demonstrate compliance. Accordingly, this study attempted to identify a minimum set of finalized policies, procedures, instructions, protocols and/or tools that will be needed for the Independent Reviewer to formulate future compliance recommendations. In addition, the Independent Reviewer asked the consultant to analyze the Commonwealth's 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. This review also encompasses required reporting commitments.

The Independent Reviewer has also instructed consultants completing studies to review any applicable Process Document and Data Set Attestation Form for CIs which require the reporting of valid and reliable data, to review previous findings by DBHDS data analysts (i.e. the Office of Data Quality and Validity or its successors) to determine what, if any, reliability and validity deficiencies (i.e., related to the data collection methodology and/or the data source system) exist, 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.

The study methodology included document review, DBHDS staff interviews, stakeholder interviews, and review and analysis of available data. The purpose of the study and the related components of the study methodology were reviewed with DBHDS staff. Following that kick-off meeting, DBHDS was asked to provide all necessary documents and to suggest interviews that provide information that demonstrates proper implementation of the Provisions and their associated Compliance Indicator(s). A full list of individuals interviewed is included in Attachment A. The full list of documents and data reviewed may be found in Attachment B. Of note, IFSP staff again provided summary documents for most CIs that clearly laid out the program activities and specific progress achieved. These were extremely helpful in ensuring a comprehensive understanding of compliance status, and much appreciated by the reviewer.

**Summary of Findings**

For each provision cited above, this 23rd Period study found that DBHDS achieved and/or sustained compliance with all of the applicable indicators, including some that were met for the first time. The following bullets cite the actions taken to address outstanding deficiencies and efforts to sustain compliance at the time of the 23rd Period.

- For CI 1.1, DBHDS achieved compliance for the first time, as a result of actions to substantially revitalize the foundation for a meaningful re-implementation of local community-based support

through the IFSP Regional Councils. DBHDS had finalized Regional Council membership selection in March 2023, with an initial orientation meeting and All-Council meeting held on 4/20/23. This meeting included a review of the IFSP State Plan and an overview of Council Orientation Materials. Council members were officially notified of their appointment in May 2023. The Regional Councils began their work together in June 2023 with planning meetings. The first IFSP Coordinated Regional Council meeting for 2023 was held on 7/13/23. On August 8/15/23, IFSP held an "All Hands Meeting" with VCU Regional Network Coordinators to brainstorm and discuss methods to utilize the current structure of the IFSP Regional Councils to fulfill the goals of the IFSP State Plan. The Regional Councils did not yet have completed work plans, but the planning effort was underway. Overall, these actions resulted in a finding that Virginia achieved this CI's requirements for the first time.

- DBHDS had sustained the achievement that was documented during the 22nd Period for CIs 1.2, 1.3, 1.4, 1.6, 1.7, 1.9, 1.10, 1.11 and 19.1.
- DBHDS had taken actions to enhance procedures for the Family-to-Family and Peer Mentoring programs to address the specific requirements of CI 19.2 and CI 19.3. These included improvement to the *Virginia Informed Choice Form and Protocol* and additional data tracking and trending capabilities. The Commonwealth met these two indicators for the first time.

The table below illustrates the most recent and the current compliance status for each Compliance Indicator.

| **III.C.2.a-f (II.D): Indicators** | **Status 23rd Period** |
|---|---|
| 1.1 The Individual and Family Support Program State Plan for Increasing Support for Virginians with Developmental Disabilities ("IFSP State Plan") developed by the IFSP State Council is implemented and includes the essential components of a comprehensive and coordinated set of strategies, as described in the indicators below, offering information and referrals through an infrastructure that provides the following:<br>• Funding resources<br>• A family and peer mentoring program<br>• Local community-based support through the IFSP Regional Councils | **Met** |
| 1.2 The IFSP State Plan includes criteria for determining applicants most at risk for institutionalization. | **Met** |
| 1.3 The IFSP State Plan establishes a requirement for an on-going communication plan to ensure that all families receive information about the program. | **Met** |
| 1.4 The IFSP State Plan includes a set of measurable program outcomes. DBHDS reports annually on progress toward program outcomes, including: | **Met** |
| 1.6 Participant satisfaction with the IFSP funding program | **Met** |
| 1.7 Knowledge of the family and peer mentoring support programs | **Met** |
| 1.9 Individuals are informed of their eligibility for IFSP funding and case management upon being placed on the waiver waitlist and annually thereafter. | **Met** |
| 1.10 IFSP funding availability announcements are provided to individuals on the waiver waitlist. | **Met** |
| 1.11 Eligibility guidelines for IFSP resources and other supports and services, such as case management for individuals on the waiver waitlist, are published on the My Life, My Community website. | **Met** |
| **III.D.5 (IV.B.9.b.): Indicators** | **Status** |
| 19.1 At least 86% of individuals on the waiver waitlist as of December 2019 have received information on accessing Family-to-Family and Peer Mentoring resources. | **Met** |

| | |
|---|---|
| 19.2 The Virginia Informed Choice Form is completed upon enrollment in the Developmental Disability waiver and as part of the annual ISP process. DBHDS will update the form to include a reference to the Family-to-Family Program and Peer Mentoring resources so that individuals and families can be connected to the support when initial services are being discussed or a change in services is requested. | **Met** |
| 19.3 The Commonwealth will track and report on outcomes with respect to the number of individuals receiving DD waiver services with whom family-to-family and the peer-to-peer supports have contact and the number who receive the service. | **Met** |

## Analysis of 23rd Review Period Findings

**23rd Review Period**
**Findings**

**III.C.2.a-f (II.D)**
**The Commonwealth shall create an individual and family support program for individuals with ID/DD whom the Commonwealth determines to be most at risk of institutionalization … In State Fiscal Year 2019, a minimum of 1000 individuals supported.**

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

| Compliance Indicator | Facts | Analysis | Conclusion<br>22nd Period<br>**23rd Period** |
|---|---|---|---|
| 1.1<br>The Individual and Family Support Program State Plan for Increasing Support for Virginians with Developmental Disabilities ("IFSP State Plan") developed by the IFSP State Council is implemented and includes the essential components of a comprehensive and coordinated set of strategies, as described in the indicators below, offering information and referrals through an infrastructure that provides the following:<br>• Funding resources<br>• A family and peer mentoring | Overall, DBHDS met the criteria for this CI. The *Individual and Family Support Program State Plan for Increasing Support for Virginians with Developmental Disabilities* (*IFSP State Plan"* developed by the IFSP State Council includes the essential components of a comprehensive and coordinated set of strategies, including funding resources, a family | DBHDS issued the current *IFSP State Plan* in 2019 and continued to make annual updates. The *FY 23 State Plan Update and Progress Report* was completed on 8/28/23, and posted to the DOJ Library. It was also shared with the IFSP State Council at the September 2023 meeting. IFSP staff again reported that they anticipated undertaking a more extensive review in the future, but this had not yet occurred.<br><br>Previously, DBHDS had issued a Departmental Instruction (DI) with regard to the IFSP (i.e., *DI 113 (TX) 20: Facilitation of Access to Resources and Supports to Enhance Community Inclusion and Engagement*). The DI, dated 9/4/20, remained current for this 23rd Period review; however, IFSP staff provided a draft revision for review. The existing DI states its purpose as to outline the supportive policies within the IFSP, as they relate to the administration of peer-to-peer mentoring, | 22nd - Not Met<br><br>**23rd - Met** |

| Compliance Indicator | Facts | Analysis | Conclusion 22nd Period **23rd Period** |
|---|---|---|---|
| program<br>• Local community-based support through the IFSP Regional Councils | and peer mentoring program and local community-based support through IFSP Regional Councils.<br><br>The IFSP Funding Program has been in continuous operation since 2013 and DBHDS continued to provide funding resources annually. In addition, IFSP staff have issued, and updated as needed, eligibility and prioritization criteria, formal guidelines, policies and procedures sufficient to implement the program. The most recent Funding Period opened on 10/16/23 and was scheduled to close on 11/14/23.<br><br>DBHDS provides for both a family and a peer mentoring program, as evidenced by vendor contract and quarterly reports.<br><br>DBHDS provided an | family-to- family mentoring, information and referral, and the IFSP community coordination efforts. As previously noted, this DI provides extensive definitions of terms, but guidance tends to be broad, non-specific and/or limited in scope. Instead, it defers to the DBHDS Central Office to "ensure that procedures are developed to comply with this DI." Specifically, the DI indicates that the procedures to be developed shall include:<br>• Processes and procedures to support the implementation of the State Plan and the state and regional council structure to build the local infrastructure to promote person-centered and family-centered resources, supports, services, and other assistance;<br>• A process for providing family and peer mentoring to provide one on one support and information to individuals and families;<br>• A process to establish criteria for identifying applicants most at risk for institutionalization; and,<br>• A process to maintain accessible, user-friendly information including information on eligibility for IFSP-Funding, case management, and other DD resources and services through a website and other mechanisms that shall be shared with individuals upon their placement on the DD Waiver Waiting List.<br><br>The draft DI provided has a revision date of 9/21/23, but IFSP staff reported this is pending finalization. Based on review of the draft document, it did not make substantive changes to any of the procedures outlined above or that would affect overall compliance.<br><br>This Compliance Indicator (CI) requires implementation of the strategies in the IFSP State Plan, specifically "offering information and referrals through an infrastructure" that includes funding | |

| Compliance Indicator | Facts | Analysis | Conclusion 22nd Period **23rd Period** |
|---|---|---|---|
| | updated contract modification, dated 4/12/22, to the original Memorandum of Agreement (MOA) with the Virginia Commonwealth University Center for Family Involvement (CFI) Partnership for People with Disabilities to show continuation of the family-to-family program for the period between 7/1/22 through 6/30/23.<br><br>DBHDS continued to work with the Arc of Virginia to implement a peer mentoring program and associated infrastructure. On 4/14/22, DBHDS executed the most recent contract renewal with the Arc.<br><br>While the Regional Councils were largely non-functional at the time of the 22nd Period review, for the 23rd Period, DBHDS had continued actions to re-institute functional | resources, family and peer mentoring programs and local community-based support through the IFSP Regional Councils. As the DI indicates, DBHDS staff acknowledge that such implementation requires a foundation of a minimum set of clear, written finalized policies, procedures, instructions, protocols and/or tools. The following paragraphs describe the status of each of these components.<br><br>**Funding Resources:** For this review, DBHDS continued to provide funding resources annually. At the time of the 22nd Period review, DBHDS unveiled a new WaMS Funding Portal, which was operational for the FY23 funding period that took place in January 2023 through February 2023. It worked successfully, with no significant issues. It remained in place for the FY24 funding period.<br><br>During this 23rd Period review, on 10/16/23, DBHDS opened the FY24 Funding Program. Applicants had approximately one month to apply for funds, with the funding period scheduled to close on 11/14/23. As described at the time of the 22nd Period review, this funding period relied on the same set of prioritization criteria and continued to operate the IFSP Funding Portal integrated into WaMS. While DBHDS has continued to make some needed improvements to the funding process and procedures since the previous review, the prioritization criteria remain unchanged.<br><br>The aforementioned DI defined the IFSP Funding Program in the following manner: subject to the availability of funds, the IFSP Funding available in accordance with 12 VAC 35-230 assists individuals on Virginia's DD Waiting List and their families with accessing resources, supports and services. While the DI did not otherwise detail guidance with regard to the operation of the funding program, DBHDS continued to maintain an extensive library of formalized policies and procedures, which they had consistently | |

| Compliance Indicator | Facts | Analysis | Conclusion 22nd Period **23rd Period** |
|---|---|---|---|
| | Regional Councils and each one was operational. | updated over time to address any programmatic changes.<br><br>For the 23rd Period review, IFSP staff disseminated various tools to support users in accessing and using the portal, including the *DBHDS IFSP Funding Guidelines*, updated 1/9/23, which remained current. the *IFSP Portal User Guide (Apply for Funds Using the DBHDS Waitlist and IFSP Portal)* dated 10/13/23, and a document entitled *IFSP-Funding Application Quick Tips Fall 2023 Version Date: 10/13/2023*. IFSP staff also created an *IFSP Funding Application Training Video (FY24)*, which was delivered live on several occasions during October 2023 and then posted to YouTube and My Life My Community (MLMC) for ongoing access.<br><br>In addition, DBHDS had a robust capacity for providing all individuals on the waitlist with time-sensitive notifications of funding availability. For this 23rd Period review, DBHDS provided the following documentation:<br>• A Process Document entitled *IFSP Outreach Materials VER002*, dated 8/18/23 and Data Set Attestation entitled *IFSP Annual Funding Award*, dated 10/2/23. These described the methodology and attested to its validity and reliability. The documents met the requirements of the Curative Action for Data Validity and Reliability.<br>• A document entitled *IFSP Annual Notification for Individuals on WWL: FY 2024 Update and Quantity Detail*, dated September 27, 2023 to show the notifications procedures were followed.<br><br>**A Family and Peer Mentoring Program:** The Settlement Agreement requires the Commonwealth to develop family-to-family and peer mentoring programs as a part of a comprehensive and coordinated set of person-centered and family-centered strategies, but also specifically to facilitate opportunities for families and individuals | |

| Compliance Indicator | Facts | Analysis | Conclusion 22nd Period **23rd Period** |
|---|---|---|---|
| | | considering congregate care receive information about options for community placements, services, and supports.<br><br>As reported previously, at this time, DBHDS continues to contract with the Virginia Commonwealth University Center for Family Involvement (CFI) Partnership for People with Disabilities to engage with individuals and families on behalf of DBHDS across a platform of programs. These efforts include the implementation of a family-to-family network to provide one-to-one emotional, informational and systems navigational support to families. Through the program, Family Navigators provide support and information, and discuss options with families so they can make the best choices for their family member with a disability. This program had been in existence for more than 15 years and is well-established. For this 23rd Period, DBHDS provided the most recent updated contract modification to the original Memorandum of Agreement (MOA), dated 6/16/23, to show continuation of the family-to-family program for the period between 7/1/23 through 12/31/23.<br><br>As reported previously, for this 23rd Period review, the primary DBHDS vehicle for the implementation of peer-to-peer supports continued to be a statewide peer mentoring system operated by The Arc of Virginia (The Arc). On 5/11/23, DBHDS executed the most recent contract renewal, which renewed the original agreement that was dated 5/26/20. The original contract described a scope of work to develop the necessary infrastructure to successfully implement a Statewide Peer Support Program, which included multiple tasks pertinent to this CI, primarily related to the development and implementation of a peer mentoring curriculum and network. The performance period for the most recent renewal was 6/4/23 through 6/3/24.<br><br>Both CFI and The Arc submitted ongoing quarterly reports of | |

| Compliance Indicator | Facts | Analysis | Conclusion 22nd Period **23rd Period** |
|---|---|---|---|
| | | activities and outcomes. Overall, DBHDS had met the requirements for implementing family and peer mentoring programs for this CI.<br><br>**Local community-based support through the IFSP Regional Councils:** Based on the existing 2019 *IFSP State Plan*, the Community Coordination program serves as the hub for family engagement and the primary vehicles for that engagement were the IFSP State and Regional Councils. While the purpose of the State Council is to provide guidance to DBHDS reflecting the needs and desires of individuals and families across Virginia, the five IFSP Regional Councils are envisioned as the primary means of providing local community-based support (e.g., identifying and/or developing local resources and sharing those with their communities.)<br><br>At the time of the 20th and 22nd Period reviews, the Regional Councils were largely non-functional due to the pandemic as well as IFSP staffing turnover. However, in March 2023, DBHDS finalized membership regional selection and, on 4/20/23, held an initial orientation meeting and All-Council meeting. This meeting included a review of the IFSP State Plan and an overview of Council Orientation Materials. Council members were officially notified of their appointment in May 2023. The Regional Councils began their work together in June 2023 with planning meetings. The first IFSP Coordinated Regional Council meeting for 2023 was held on 7/13/23. For this 23rd Period review, the Regional Councils did not yet have finalized work plans, but the planning effort was underway. On August 8/15/23, IFSP held an "All Hands Meeting" with VCU Regional Network Coordinators to brainstorm and discuss methods to utilize the current structure of the IFSP Regional Councils to fulfill the goals of the IFSP State Plan.<br><br>IFSP staff reported the next Council recruitment period is beginning in October 2023. The program will also continue to work with CFI | |

| Compliance Indicator | Facts | Analysis | Conclusion<br>22nd Period<br>**23rd Period** |
|---|---|---|---|
| | | staff to seed open Council positions and conduct outreach toward prospective members. | |
| 1.2<br>The IFSP State Plan includes criteria for determining applicants most at risk for institutionalization. | For this 23rd Period review, DBHDS continued to meet the requirements of this CI.<br><br>At the time of the 22nd Period review, DBHDS had streamlined the prioritization of funding categories, based on the waiver waitlist (WWL) Prioritization criteria (i.e., as defined in 12VAC30-122-90), developed an IFSP Funding Portal as a module in WaMS and finalized a methodology for implementation. These remained in effect for the 23rd Period review.<br><br>The current *FY 23 State Plan Update and Progress Report,* dated 8/28/23, incudes these funding prioritization criteria. | Previous reviews consistently recommended that DBHDS should finalize and formalize the definition of "most at risk for institutionalization" as it impacts eligibility requirements and program structure for the IFSP Funding Program, beyond the existing first-come, first-served approach.<br><br>Over the course of the multiple reviews, DBHDS proposed varied strategies for prioritization criteria for determining applicants most at risk for institutionalization. By the time of the 22nd Period review, DBHDS had developed an IFSP Funding Portal in WaMS, finalized a Process Document methodology and provided thorough documentation to show it met this CI. It included funding categories and criteria that would help address different types of needs and move away from exclusively a "first-come, first-served" process. It streamlined the prioritization of funding categories, based on the WWL Prioritization criteria as defined in 12VAC30-122-90. The final prioritization criteria provided for two categories for fund distribution:<br>• Fifty percent (50%) of ISFP annual funding would be devoted to applicants in Priority 1, with approval based on the application and the individual's scores for the *Critical Needs Summary*. Each approved recipient would receive $1,000.<br>• The remaining 50% of the annual funding amount would be used to fund applications from individuals in Priorities 2 and 3, with $500 per approved recipient. To avoid the potential or perceived inequities in the former "first-come, first-served" methodology, eligible applications would be funded based on | 22nd - Met<br><br>**23rd - Met** |

| Compliance Indicator | Facts | Analysis | Conclusion 22nd Period **23rd Period** |
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| | | a randomized selection. Of note, to further expand the reach of the funding to the larger population, Priority 2 and 3 applicants approved in one funding cycle could still apply in the next cycle, but applicants who did not previously receive funds would have priority. IFSP staff indicated they will need data to determine whether two funding cycles will be sufficient enough to ensure that funds are distributed to new and different people over the course of three years.<br>• If funds remained available after disbursement to all approved applicants are disbursed in a funding period, an additional application period would be offered, following the same process described above.<br><br>For this 23rd Period review, DBHDS continued to meet the requirements of this CI. The prioritization criteria described above remained in effect throughout the 23rd Period review and DBHDS incorporated them into the current *FY 23 State Plan Update and Progress Report*, dated 8/28/23.<br><br>While IFSP staff implemented some improvements in the methodology, per feedback from various sources [i.e., applicants, My Life My Community (MLMC) call center staff, satisfaction survey responses, and collaboration with the IFSP State and Regional Councils], the prioritization criteria remained essentially unchanged from the 22nd Period. As a result, DBHDS determined that IFSP staff did not need to update IFSP Funding Guidelines from FY23. Reported improvements include the following:<br>• IFSP updated the application process and portal features for the FY24 funding period. Critical enhancements include a redesign to ensure the portal is supported on dynamic multiple apps, browsers and mobile, the ability for applicants to make changes to and/or delete their application as long as | |

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| | | the application period is open, and the addition of a drop-down menu for applicants to indicate their intended use of funds.<br>• For the FY24 funding period, there is no longer a staggered application open period linked to individuals' priority status on the WWL. Instead, individuals may apply at any time throughout the funding period. This change was intended to prevent confusion when applicants were not aware of their priority status. While priority status is still a determining factor, that identification is done in the background through the Portal. | |
| 1.3<br>The IFSP State Plan establishes a requirement for an on-going communication plan to ensure that all families receive information about the program. | The *IFSP State Plan Update and Progress Report,* dated 8/28/23, continued to include a goal that read, "DBHDS develops a comprehensive communication plan that provides information to individuals and families as well as stakeholders who support them at least semi-annually."<br><br>The *IFSP Communications Plan FY 2024,* updated 8/24/23, encompasses a large number of documents and communication activities, categorized by type (i.e., general information and referral, | The *IFSP State Plan Update and Progress Report,* dated 8/28/23, continued to include a goal that read, "DBHDS develops a comprehensive communication plan that provides information to individuals and families as well as stakeholders who support them at least semi-annually."<br><br>Consistent with previous reports, the current version of the communication plan (i.e., *IFSP Communications Plan FY 2024,* updated 8/24/23) encompasses a large number of documents and communication activities, categorized by type (i.e., general information and referral, funding program, communications policies, MLMC, information to key stakeholders, state plan, and council recruitment.) For each document or activity, the plan cites the target audience, purpose and objective, timing and frequency and description and venue. The plan notes that it will be updated as needed and describes the updating process.<br><br>IFSP staff continued to use, and update, the *IFSP: First Steps (First Steps)* as the annual IFSP program brochure. First published in November 2020, *First Steps,* is intended to guide families through a basic overview of the IFSP program at DBHDS, Virginia's | **22nd – Met**<br><br>**23rd - Met** |

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| | funding program, communications policies, MLMC, information to key stakeholders, state plan, and council recruitment.) For each document or activity, the plan cites the target audience, purpose and objective, timing and frequency and description and venue. The plan notes that it will be updated as needed.<br><br>IFSP staff continued to use, and update, the *IFSP: First Steps* as the annual IFSP program brochure<br><br>For this 23rd Period review, IFSP staff continued to use the annual WWL attestation process and an annual mailer campaign as the primary vehicles for ensuring that individuals and families on the waiver waitlist receive needed communications about their eligibility for the IFSP Funding Program, family | Developmental Disability (DD) system, and the resources that are available for people who are waiting for a DD Waiver Slot.<br><br>For this 23rd Period review, IFSP staff continued to use the annual WWL attestation process and an annual mailer campaign as the primary vehicles for ensuring that individuals and families on the waiver waitlist receive needed communications about their eligibility for the IFSP Funding Program, family and peer mentoring supports, case management options and the MLMC website. The annual WWL attestation process for this period took place in September 2023. Based on DBHDS report, in addition to the cover letter, which included Funding Program key dates, and the updated version of *IFSP: First Steps,* the Annual Notification postal mailer included a dual-sided postcard for families on the WWL. The postcard contained an announcement that families could complete the required Annual Choice form and optional Needed Services form online, included a link to the site where people could fill out these forms and a link to the Quick Tips document, which was linked to the MLMC Waiver Information page. The back of the postcard contained a QR code and link to IFSP's FY 2023 Annual Satisfaction Survey.<br><br>DBHDS also provided documentation to show the dissemination process and outcomes. This included the *Process Document entitled IFSP Outreach Materials VER002*, dated 8/18/23 and Data Set Attestation entitled *IFSP Annual Funding Award*, dated 10/2/23. These described the methodology and attested to its validity and reliability. The documents met the requirements of the Curative Action for Data Validity and Reliability. | |

| Compliance Indicator | Facts | Analysis | Conclusion<br>22nd Period<br>**23rd Period** |
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| | and peer mentoring supports, case management options and the MLMC website. The annual WWL attestation process for this period took place in September 2023.<br><br>Based on DBHDS report, in addition to the cover letter, which included Funding Program key dates, and the updated version of *IFSP: First Steps*, the Annual Notification postal mailer included a dual-sided postcard for families on the WWL. The postcard contained an announcement that families could complete the required Annual Choice form and optional Needed Services form online, included a link to the site where people could fill out these forms and a link to the Quick Tips document, which was linked to the MLMC Waiver Information page. The back of the postcard contained a QR code and | | |

| Compliance Indicator | Facts | Analysis | Conclusion<br>22nd Period<br>**23rd Period** |
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| | link to IFSP's FY 2023 Annual Satisfaction Survey.<br><br>DBHDS also provided documentation to show the dissemination process and outcomes. This included the *Process Document entitled IFSP Outreach Materials VER002*, dated 8/18/23 and Data Set Attestation entitled *IFSP Annual Funding Award*, dated 10/2/23. These described the methodology and attested to its validity and reliability. The documents met the requirements of the Curative Action for Data Validity and Reliability. | | |
| 1.4<br>The IFSP State Plan includes a set of measurable program outcomes. DBHDS reports annually on progress toward program outcomes, including… | For the 23rd Period review, on 8/28/23, DBHDS issued an *IFSP State Plan Update and Progress Report* for FY23. It did not include any changes to the measurable outcomes, which were found to support compliance during the 22nd Period review. | The 22nd Period review found that DBHDS issued an *IFSP State Plan Update* in February, 2023. It included updated goals and objectives and a report of progress for FY22. With regard to measurability, some data methodologies were not yet fully fleshed out and could benefit from some additional work. However, for the two outcomes specifically required for this CI that remained outstanding (i.e., as defined in CI 1.6 and CI 1.7 below), a review of the measurement methodologies did not reveal any significant deficiencies. As a result, overall, DBHDS demonstrated that the Commonwealth met the requirements of this CI. | 22nd – Met<br><br>**23rd - Met** |

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| | Therefore, the previous finding that the Commonwealth met the requirements of this CI remained true for the 23rd Period review. | For the 23rd Period review, on 8/28/23, DBHDS issued an additional *IFSP State Plan Update and Progress Report* for FY23. This did not include any changes to the measurable outcomes. Therefore, the previous finding that the Commonwealth met the requirements of this CI remained true for the 23rd Period review. | |
| 1.6<br>Participant satisfaction with the IFSP funding program | The *IFSP State Plan Update and Progress Report FY23*, dated 8/23/23, includes two program outcomes related to determining participant satisfaction with the IFSP funding program.<br><br>For this 23rd Period, and as previously recommended, DBHDS updated the Process Document entitled *DD IFSP ANNUAL STSFCTN SRVY DATA VRFCTN VER 002*, dated 7/27/23, to enhance measurability data validity and reliability. It provided additional detail about how to extract the raw data file from Qualtrics and how to use it to calculate the data for percentages. Revisions also clearly defined the numerator and | Overall, the documentation provided at the time of the 22nd Period review appeared to be sufficient to meet the requirements of this CI and that of CI 1.4. However, that study found that, going forward, the 1/15/23 Process Document, entitled *DD IFSP ANNUAL STSFCTN SRVY DATA VRFCTN VER 001,* should be reformulated so it could stand on its own, with sufficient detail for it to be implemented correctly. For example, one step stated, "Perform query to extract the email addresses for all individuals on the waitlist," but did not provide any additional detail about how to perform or even how to obtain the query. DBHDS staff provided the query upon request, which was sufficient to evidence the process. However, to ensure the data are collected in the appropriate manner each time the process is completed, they needed to update the Process Document, by either attaching the query or identifying it by name and current effective date. Similarly, the Process Document needed to provide sufficient detail about how to extract the raw data file from Qualtrics and use it to calculate the data for percentages. DBHDS also provided a related Data Set Attestation, dated 4/10/23, that found no deficiencies, but it did not address the missing information described above.<br><br>For this 23rd Period, DBHDS updated the Process Document entitled *DD IFSP ANNUAL STSFCTN SRVY DATA VRFCTN VER 002*, dated 7/27/23. It provided additional detail about how to extract the raw data file from Qualtrics and how to use it to calculate the data for percentages. Revisions also clearly defined the numerator and | 22nd – Met<br><br>**23rd - Met** |

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| | denominator and a process to separately capture the response to two variables (i.e., do not know vs have not used). This appeared to address the previously noted concerns. The related Data Set Attestation, dated 10/2/23, was appropriately completed and addressed the adequacy and sufficiency of the mitigation strategies.<br><br>The *IFSP State Plan Update and Progress Report FY23* provided an FY22 progress report on participant satisfaction with the IFSP funding program. On 10/13/23, DBHDS issued a report entitled *Individual and Family Support Program FY 23 Annual Satisfaction Survey* with results from the FY23 funding period. | denominator and a process to separately capture the response to two variables (i.e., do not know vs have not used). This appeared to address the previously noted concerns. The related Data Set Attestation, dated 10/2/23, was appropriately completed and addressed the adequacy and sufficiency of the mitigation strategies.<br><br>For the 23rd Period review, the *IFSP State Plan Update FY23*, dated 8/28/23, provided a progress report on participant satisfaction with the IFSP funding program, with data from FY22 funding period.<br><br>In addition, on 10/13/23, DBHDS issued a report entitled *Individual and Family Support Program FY 23 Annual Satisfaction Survey* with results from the FY23 funding period. This document indicated that 71% of survey respondents reported overall satisfaction with the IFSP Funding Program. It also included a Plan for Action to focus on plans to improved response rates in the future, so that the data could be reliably used to support data-driven decision making about the Funding Program. | |
| 1.7<br>Knowledge of the family and peer mentoring support program. | At the time of the 22nd Period review, the *IFSP State Plan Update*, dated 2/7/23, included a goal that read, "Goal 4: The | For the 23rd Period review, *The IFSP State Plan Update and Progress Report FY23*, dated 8/28/23, included a goal that read, "Goal 4: The IFSP Program will connect individuals to appropriate supports and services while waiting on the waiting list through My Life My Community, Family to Family, Peer Supports and/or the Regional | 22nd – Met<br><br>**23rd - Met** |

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| | IFSP Program will connect individuals to appropriate supports and services while waiting on the waiting list through My Life My Community, Family to Family, Peer Supports and/or the Regional Council Structure." It did not include a specific outcome target related to knowledge of the family and peer mentoring support programs. However, as reported previously, the annual satisfaction survey process included measures for this CI. For this 23rd period, these facts remained the same.<br><br>For this 23rd Period study, DBHDS revised the *DD IFSP ANNUAL STSFCTN SRVY DATA VRFCTN VER 002*, dated 7/27/23, to enhance data validity. In addition, the related Data Set Attestation, dated 10/2/23, was appropriately completed and addressed the | Council Structure." It did not include a specific outcome target related to knowledge of the family and peer mentoring support programs. However, as reported previously, the annual satisfaction survey process included measures for this CI.<br><br>The 22nd Period study found that the Process Document entitled *DD IFSP ANNUAL STSFCTN SRVY DATA VRFCTN VER 001* indicated one of its intentions was to determine the percent of survey respondents familiar with family and peer mentoring support programs, and met the overall requirements for this CI. However, it also found the framing of the two applicable measures could impact their validity. To ensure valid and reliable data, the survey needed to consider isolating the number of respondents who specifically "did not know" from those who "had not used." For this 23rd Period study, DBHDS revised the *DD IFSP ANNUAL STSFCTN SRVY DATA VRFCTN VER 002*, dated 7/27/23, as needed. In addition, the related Data Set Attestation, dated 10/2/23, was appropriately completed and addressed the adequacy and sufficiency of the mitigation strategies.<br><br>On 10/13/23, DBHDS issued a report entitled *Individual and Family Support Program FY 23 Annual Satisfaction Survey* with results from the FY23 funding period. This document indicated that 28% of respondents had knowledge of the family mentoring program and 36% had knowledge of the peer mentoring program. The document further stated that IFSP staff were developing strategies to address the low levels of awareness of these resources (i.e., asking VCU to report on their referral sources and to continue working with VCU and The Arc of Virginia to explore new ways to promote their services and to educate support coordinators/case managers/CSB intake staff about these services). | |

| Compliance Indicator | Facts | Analysis | Conclusion<br>22nd Period<br>**23rd Period** |
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| | adequacy and sufficiency of the mitigation strategies.<br><br>On 10/13/23, DBHDS issued a report entitled *Individual and Family Support Program FY 23 Annual Satisfaction Survey* with results from the FY23 funding period related to knowledge of the family and peer mentoring support program. | | |
| 1.9<br>Individuals are informed of their eligibility for IFSP funding and case management upon being placed on the waiver waitlist and annually thereafter. | DBHDS informs individuals of their eligibility for IFSP funding upon being placed on the waiver waitlist and annually thereafter. For this 23rd Review Period, the annual notification occurred during September 2023<br><br>DBHDS had updated multiple documents as needed to clarify eligibility for waiver waitlist (WWL) case management, and made outreach information available on MLMC and as a part the annual WWL | **Eligibility for IFSP Funding:** As previously described with regard to CI 1.3, DBHDS implements an annual waiver waitlist eligibility attestation process in which every individual on the waitlist received a letter on an annual basis. For this Review Period, the annual notification occurred during September 2023. The annual waiver waitlist eligibility attestation packet included an insert (i.e., *First Steps*) that described various supports for which individuals on the waiting list might be eligible. It also included a notification that individuals might be able to access financial assistance through the IFSP and provided a link to obtain further information.<br><br>**Eligibility for case management:** DBHDS indicated it informs individuals of their eligibility for case management upon being placed on the WWL and annually thereafter as a part of the annual waiver waitlist eligibility attestation process.<br><br>For this 23rd Period review, in addition to the annual notification described above, DBHDS had maintained or updated the following documents as needed to make this information available: | 22nd - Met<br><br>**23rd - Met** |

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| | mailing. This included a revision to the *First Steps* outreach document to provide a more direct link to the document *Information on Case Management Eligibility for Individuals on the DD Waiver Waitlist.*<br><br>Since the 22nd study, DBHDS has worked with MLMC to ensure that links to all IFSP documents remain operational, including a manual review of the site by IFSP staff to update documents including cross-referencing with files from the previous public-facing storage system.<br><br>At the time of the 23rd Period review, this study found the MLMC website provided current documents and that links were operational. | • *Navigating the Developmental Disability Waivers: A Guide for Individuals, Families and Support Partners: Seventh Edition Updated January 2023.*<br>• *Support Coordination: A Handbook For Developmental Disabilities Waiver Support Coordination*, dated 2/27/23, reflected the information in *Chapter IV Covered Services and Limitations* in the *Developmental Disabilities Waivers (BI,FIS,CL ) Services Manual.*<br>As well as language in *Chapter 4: Support Coordination: Assessment and Intake:* "The CSB/BHA shall provide anyone interested in accessing DD Waiver Services with a DBHDS provided resource guide that contains information including but not limited to case management eligibility and services, family supports, including the IFSP Funding Program, family and peer supports, and information on the My Life, My Community Website, information on how to access REACH services, and information on where to access general information." Hyperlinks in this section provide direct links to IFSP-First Steps and to the MLMC website.<br>• *Support Coordination/Case Management Options for Individuals on the DD Waivers Waitlist,* which also incorporated *Support Coordination: Questions and Answers for People with DD and their Families,* dated 10/31/22.<br>• In response to concerns this study noted at the time of the 22nd Period review, IFSP staff modified the language in *IFSP-First Steps* dated August 2023. The language now reads, "How can I get support coordination? Contact your local CSB/BHA to ask about support coordination. Your CSB/BHA staff will guide you through the process of determining eligibility for support coordination." It also mow includes a more direct link to *Information on Case Management Eligibility for Individuals on the DD Waiver Waitlist* Clicking on "determining eligibility" now takes the reader to the link for *Information on Case Management Eligibility for* | |

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| | | *Individuals on the DD Waiver Waitlist* on the MLMC website, which in turn opens a document entitled *Support Coordination/Case Management Options for Individuals on the DD Waivers Waitlist.*<br>• DBHDS has worked with MLMC to ensure that links to all IFSP documents remain operational. Since the 22nd study, the IFSP staff manually reviewed the site to update documents and cross-referenced with files from the previous public-facing storage system. At the time of the 23rd Period review, this study found the MLMC website provided current documents and that links were operational | |
| 1.10<br>IFSP funding availability announcements are provided to individuals on the waiver waitlist. | As described above with regard to CI 1.3, IFSP staff implemented procedures to ensure that every individual on the waitlist would receive a timely notification about the upcoming IFSP funding period, either by email or by postal service.<br><br>The Process Document entitled *IFSP Outreach Materials VER002*, dated 8/18/23 and Data Set Attestation entitled *IFSP Annual Funding Award*, dated 10/2/23, described the methodology and attested to its validity and reliability. The documents | For this 23rd Period review, IFSP staff had implemented procedures to ensure that every individual on the waitlist would receive a timely notification about the upcoming IFSP funding period, either by email or by postal service. As described above with regard to CI 1.3, IFSP staff had developed a sufficiently robust methodology for providing IFSP funding availability announcements to individuals on the waiver waitlist. The Process Document entitled *IFSP Outreach Materials VER002*, dated 8/18/23 and Data Set Attestation entitled *IFSP Annual Funding Award*, dated 10/2/23, described the methodology and attested to its validity and reliability. The documents met the requirements of the *Curative Action for Data Validity and Reliability*.<br><br>In addition, DBHDS reported that the Office of Integrated Supports (OISS) provided IFSP with point in time data of 15,109 individuals on the WWL as of July 1, 2023. DBHDS then provided promotional materials electronically to all individuals on the WWL with a valid email address in WaMs, or from a past IFSP-Funding application request. Emails were sent to 12,471 individuals on the WWL . Of these, 1,455 were undeliverable connected by OISS to 1,023 individuals on the WWL; therefore, it appeared that 11,448 individuals on the WWL received the email notification. For 2,638 | 22nd - Met<br><br>**23rd - Met** |

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| | met the requirements of the *Curative Action for Data Validity and Reliability*.<br><br>This process, as implemented during the annual WWL notification, ensured notifications to at least14,086 of 15019 (i.e., 94%) of the individuals on the WWL. | individuals who did not have an email address available in WaMS, DBHDS mailed hardcopies of the materials to 3,224 physical addresses on the WWL as of 7/1/23. DBHDS reported that none of these had been returned as undeliverable. Based on these data, it appeared this was sufficient to show that more than 86% (14,086/15019 or 94%) of the individuals on the WWL received information about family and peer mentoring. Of note, for the 1,455 emails that were undeliverable, DBHDS also intended to send a postal mailer in October 2023.<br><br>DBHDS also provided a Process Document entitled *IFSP Outreach Materials VER002*, dated 8/18/23 and Data Set Attestation entitled *IFSP Annual Funding Award*, dated 10/2/23. These described the methodology and attested to its validity and reliability. The documents met the requirements of the *Curative Action for Data Validity and Reliability.* | |
| 1.11<br>Eligibility guidelines for IFSP resources and other supports and services, such as case management for individuals on the waiver waitlist, are published on the My Life, My Community website | The MLMC website was operational and DBHDS had posted to it various eligibility guidelines for IFSP resources and other supports and services. | The MLMC website continued to be operational and DBHDS had posted to it various eligibility guidelines for IFSP resources and other supports and services. In that regard, DBHDS had an effective mechanism for posting eligibility guidelines for IFSP resources and other supports and services for easy access on the internet.<br><br>For this review, as noted with regard to CI 1.9 above, DBHDS has worked with MLMC to ensure that links to all IFSP documents remain operational. Since the 22nd study, the IFSP staff manually reviewed the site to update documents and cross-referenced with files from the previous public-facing storage system). IFSP staff continued to update pertinent documents throughout the 23rd Period review, based on any revisions.<br><br>The *Individual and Family Support Program Guidelines and FAQs,* updated 1/9/23 continued to be applicable. As reported previously, it was | 22nd - Met<br><br>**23rd - Met** |

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| | | thorough and clearly written, and served as a valuable resource for individual and families seeking funding assistance through the IFSP. These documents provided a clear description of how the program would serve those who were "most at risk for institutionalization," as described with regard to CI 1.2. DBHDS had updated documents to provide this information, and these key documents and information were available on the MLMC website in October 2023, as described:<br>• In January 2023, DBHDS had updated the *Navigating the Developmental Disability Waivers: A Guide for Individuals, Families and Support Partners: Seventh Edition* to include a clear and consistent description of case management options for individuals on the waitlist.<br>• The MLMC website continued to post the *Support Coordination/Case Management Options for Individuals on the DD Waivers Waitlist,* dated 10/3/22. It provided clear guidelines for individuals and families with regard to the types of needs that would be considered as a "special service need." It was positive to see that IFSP staff ensured that this information was referenced in the *Resources for Families* webpage as well as the *General Information* webpage.<br>• As of the 20th Period review, and as described with regard to CI 1.9, DBHDS had clarified the guidelines with regard to the availability of support coordination of individual on the WWL and published them in *Chapter IV Covered Services and Limitations in the Developmental Disabilities Waivers (BI,FIS,CL)Services Manual* on 2/15/22. This described the expectations for CSBs to apply those consistently. In addition, the documents on the MLMC website had been updated to reflect this information. DBHDS updated this document on 11/1/22 and for this 23rd Period, it continued to include the above information. | |

**23rd Review Period**
**Findings**

**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.**

(**IV.B.9.b: PSTs and the CSB case manager shall coordinate with the specific type of community providers identified in the discharge plan as providing appropriate community- based services for the individual, to provide individuals, their families, and, where applicable, their Authorized Representative with opportunities to speak with those providers, visit community placements (including, where feasible, for overnight visits) and programs, and facilitate conversations and meetings with individuals currently living in the community and their families, before being asked to make a choice regarding options. The Commonwealth shall develop family- to-family and peer programs to facilitate these opportunities.**)

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| 19.1<br>At least 86% of individuals on the waiver waitlist as of December 2019 have received information on accessing Family-to-Family and Peer Mentoring resources. | The annual WWL attestation provided information, including the *First Steps* documentation, on accessing about family and peer mentoring resources to individuals on the WWL.<br><br>DBHDS provided a Process Document entitled *IFSP Outreach Materials VER002*, dated 8/18/23 and Data Set Attestation entitled *IFSP Annual Funding Award*, dated 10/2/23, continued to be sufficiently robust to ensure that at least 86% of individuals on the waiver waitlist have received this information. These | Consistent with reporting from the 23rd Period review, DBHDS continued to use notifications provided as a part of the annual WWL attestation process to inform individuals on the waitlist about family and peer mentoring resources. As described above with regard to CI 1.3, the *First Steps* documentation distributed as a part of the annual WWL attestation process included links to the family and peer mentoring programs.<br><br>The annual WWL process, as described in the Process Document entitled *IFSP Outreach Materials VER002*, dated 8/18/23 and Data Set Attestation entitled *IFSP Annual Funding Award*, dated 10/2/23, continued to be sufficiently robust to ensure that at least 86% of individuals on the waiver waitlist have received this information. These described the methodology and attested to its validity and reliability. The documents met the requirements of the Curative Action for Data Validity and Reliability<br><br>DBHDS also provided documentation to show they followed the process and were able to report valid and reliable data. Based on the number of mailings and notifications completed, it appeared this was sufficient to show | **22nd - Met**<br><br>**23rd - Met** |

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| | described the methodology and attested to its validity and reliability. The documents met the requirements of the Curative Action for Data Validity and Reliability<br><br>DBHDS also provided documentation to show they followed the process and were able to report valid and reliable data. Based on the documentation provided, this was sufficient to with at least 86% of the individuals on the WWL. | with at least 86% of the individuals on the WWL received information about family and peer mentoring.<br><br>DBHDS reported that the Office of Integrated Supports (OISS) provided IFSP with point in time data of 15,109 individuals on the WWL as of July 1, 2023. DBHDS then provided promotional materials electronically to all individuals on the WWL with a valid email address in WaMs, or from a past IFSP-Funding application request. Emails were sent to 12,471 individuals on the WWL . Of these, 1,455 were undeliverable connected by OISS to 1,023 individuals on the WWL; therefore, it appeared that 11,448 individuals on the WWL received the email notification. For 2,638 individuals who did not have an email address available in WaMS, DBHDS mailed hardcopies of the materials to 3,224 physical addresses on the WWL as of 7/1/23. DBHDS reported that none of these had been returned as undeliverable. Based on these data, it appeared this was sufficient to show that more than 86% (i.e., 14,086/15019 or 94%) of the individuals on the WWL received information about family and peer mentoring. Of note, for the 1,455 emails that were undeliverable, DBHDS also intended to send a postal mailer in October 2023. | |
| 19.2<br>The Virginia Informed Choice Form is completed upon enrollment in the Developmental Disability waiver and as part of the annual ISP process. DBHDS will update the form to include a reference to the Family-to-Family Program and Peer Mentoring resources so that individuals and families can be connected to the support | For this 23rd Period review, DBHDS had made modifications to the *Virginia Informed Choice Form and Protocol: FY23 Update*, dated 8/29/23, which had gone through the required fiscal analysis and public comment processes, and was partially integrated it into WaMS.<br><br>The protocol also clearly specified that the *Virginia Informed Choice Form* must be | At the time of the 22nd Period review, DBHDS provided a document entitled *Virginia Informed Choice Form: FY23 Update*, dated 2/28/23. The update provided a sample revised *Virginia Informed Choice Form* as it appeared in WaMS. The summary stated that additions were currently being made to the form, but would need to go through fiscal analysis and public comment processes before they can be required. It projected this version of the *Virginia Informed Choice Form* would be available for use prior to FY24.<br><br>Based on review of the sample *Virginia Informed Choice Form* at that time, it appeared it would have the capacity, with some minor recommended revisions, to collect sufficient information to enable DBHDS to meet the requirements outlined in Provision III.D.5 and CI 19.2, as well as serve as the basis for collecting the data required for CI 19.3. The 22nd Period study also found a need for development and implementation of | 22nd - Not Met<br><br>**23rd - Met** |

| Compliance Indicator | Facts | Analysis | Conclusion |
|---|---|---|---|
| when initial services are being discussed or a change in services is requested. | completed whenever new services are requested, when the individual wants to move to a new location, when there is a request for a change in waiver provider(s), when the individual is dissatisfied with the current provider and when making a Regional Support Team (RST) referral for an individual with a DD Waiver<br><br>The form includes references and contact information for both the family and peer mentoring resources.<br><br>The revised form collects needed information regarding whether the individual was considering a sponsored home or congregate residential setting, as well as whether the individual requested a referral for a to be connected to the family and/or peer mentoring support).<br><br>The protocol guidance strengthened the guidance to Support Coordinators to ensure individuals were receiving an adequate explanation of the purpose of the family and peer mentoring and the specific | appropriate policies and procedures for Support Coordinators related to documenting the provision of information and referrals, and a clear Process Document outlining all the required steps for collecting and aggregating the data, this would allow DBHDS and entities providing family and peer mentoring to readily identify and track the outcomes (i.e., identification of individuals considering sponsored homes or congregate residential settings; documentation to show they were offered opportunities to speak to individuals currently living in the community and their families, before being asked to make a choice regarding options; and an indication of those that chose a referral to be connected to the family and peer mentoring support)as required.<br><br>For this 23rd Period review, DBHDS had made modifications to the *Virginia Informed Choice Form,* which had gone through the required fiscal analysis and public comment processes, and was partially integrated it into WaMS.<br>• The revised *Virginia Informed Choice Form* collected needed information (i.e., whether the individual was considering a sponsored home or congregate residential setting, as well as whether the individual requested a referral for a to be connected to the family and/or peer mentoring support).<br>• The revision to the accompanying *Virginia Informed Choice Form* included a section that required the Support Coordinator to document confirmation of discussion of all applicable waiver service options by checking the options listed, including all residential options (i.e., including but not limited to sponsored residential, group home residential four beds or less and group home residential five beds or more).<br>• The protocol also clearly specified that the *Virginia Informed Choice Form* must be completed whenever new services are requested, when the individual wants to move to a new location, when there is a request for a change in waiver provider(s), when the individual is dissatisfied with the current provider and when making a Regional Support Team (RST) referral for an individual with a DD Waiver. | |

| Compliance Indicator | Facts | Analysis | Conclusion |
|---|---|---|---|
| | referral processes to follow. | At the time of the 22nd Period, the study found that the guidance needed to be strengthened to ensure individuals were receiving an adequate explanation of the purpose of the resources. In other words, in addition to Support Coordinators being instructed with regard to the requirement to offer the opportunities, DBHDS also needed to provide clear expectations with regard to the specific referral process to follow. For this 23rd Period review, DBHDS updated the accompanying guidance for Support Coordinators related to the implementation of the revised process. The *Virginia Informed Choice Form and Protocol: FY23 Update,* dated 8/29/23, included updated guidance which clarified that "The SC must provide confirmation that information has been provided to the individual and family regarding the opportunity to speak with other individuals receiving BI/FIS/CL Waiver services who live and work successfully in the community or with their family members. To accomplish this, the SC should confirm that the information included on the form for VCU's Center for Family Involvement, and the Arc of Virginia has been provided. The SC must offer to assist with these referrals and document the individual/families desire for this assistance where indicated." | |
| 19.3<br>The Commonwealth will track and report on outcomes with respect to the number of individuals receiving DD waiver services with whom family-to-family and the peer-to-peer supports have contact and the number who receive the service. | For the 23rd Period review, CFI and The Arc, (i.e., which operate the about family and peer mentoring programs respectively) provided waiver-specific data for individuals receiving family-to-family and peer mentoring supports. Effective 1/1/23, CFI updated its reporting to begin providing a report of the number of individuals who currently were on the Waiver, on the WWL or not on the WWL/was unsure of WWL status. Based on review | For the 23rd Period review, CFI and The Arc, (i.e., which operate the family and peer mentoring programs respectively) provided waiver-specific data for individuals receiving family-to-family and peer mentoring supports. Effective 1/1/23, CFI updated its reporting to begin providing a report of the number of individuals who currently were on the Waiver, on the WWL or not on the WWL/was unsure of WWL status. Based on review of the quarterly reports from The Arc, that organization also reported referral source and waiver/waiver waitlist status.<br><br>In addition, for this 23rd Period review, DBHDS reported additional process enhancements related to these outcomes.<br>• Effective 8/31/23, DBHDS began sending a welcome letter to all new DD waiver enrollees to provide them with resources for understanding the disability service system and all the available options for services and support. In addition to various materials | 22nd - Not Met<br><br>**23rd - Met** |

| Compliance Indicator | Facts | Analysis | Conclusion |
|---|---|---|---|
| | of the quarterly reports from The Arc, that organization also reported referral source and waiver/waiver waitlist status.<br><br>DBHDS reported additional process enhancements related to tracking family-to-family and peer-to-peer supports that are offered to individuals and families pursuant to their consideration related to sponsored homes or any congregate setting.<br><br>Effective 8/31/23, DBHDS began sending a welcome letter to all new DD waiver enrollees to provide them with resources for understanding the disability service system and all the available options for services and support including an overview of Family and Peer Support as an opportunity to talk to another individual or family member who use waiver services.<br><br>With the implementation of the revised *Virginia Informed Choice Form and Protocol*, DBHDS had enhanced capability to track whether individuals considering group homes of five beds or | and a description of the role of Support Coordination, the letter provides an overview of Family and Peer Support as an opportunity to talk to another individual or family member who use waiver services, and provides contact information.<br>• With the implementation of the revised *Virginia Informed Choice Form and Protocol*, DBHDS had enhanced capability to track whether individuals considering group homes of five beds or more access family or peer mentoring. While this did not yet allow similar tracking for those considering sponsored residential settings or smaller group homes, it was a significant step forward. Going forward, DBHDS and the contracted family and peer mentoring program providers should consider how they might further expand these tracking opportunities.<br>• With regard to outcomes, DBHDS staff reported that during FY23, data indicated that almost 50% of individuals who changed providers transitioned from less integrated settings to more integrated settings. DBHDS did not yet have enough data to complete an analysis of how the use of family and peer mentoring supports might impact individuals' choices of sponsored homes or congregate residential settings. However, as they track these data over time, they might be able to make at least some inferences about whether changes in use of family and peer mentoring supports correlate with changes in the choices of setting types. | |

| Compliance Indicator | Facts | Analysis | Conclusion |
|---|---|---|---|
| | more access family or peer mentoring.<br><br>With regard to outcomes, DBHDS staff reported that during FY23, data indicates that almost 50% of individuals who changed providers transitioned from less integrated settings to more integrated settings. | | |

**Recommendations:**

1. For CI 19.3, DBHDS and the contracted family and peer mentoring program providers should consider how they might further expand options for tracking outcomes related to individuals and families who are considering sponsored homes or congregate residential settings.

**Attachment A: Interviews**

1. Heather Norton, Assistant Commissioner, Developmental Services
2. Heather Hines, IFSP Program Director

**Attachment B: Documents Reviewed**

1. IFSP Summary of Activities 9.1.2023
2. IFSP-Funding Portal User Guide 10.13.2023
3. IFSP-Funding Quick Tips 10.13.2023
4. IFSP-Funding Announcement Archives 9.28.2023
5. IFSP-Funding Portal Quick Reference Guide 10.10.2023
6. IFSP-Funding Program Guidelines and FAQs 10.10.2023
7. IFSP-Funding Timeline 9.26.2023
8. IFSP DI 113.IFSP.Draft revision 9.21.23.docx
9. Virginia's Individual and Family Support Program State Plan for Increasing Supports for Virginians with Developmental Disabilities FY 23 Update, 8.28.23
10. IFSP 2023 State and Regional Council Roster 8.7.2023
11. IFSP SC Minutes April 2023 4.30.2023
12. IFSP SC Minutes June 2023 6.30.2023
13. IFSP SC Minutes September 2023 9.22.2023
14. IFSP State and Regional Council Summary of Activities 9.1.2023
15. IFSP Communications Plan FY 2024 8.24.2023
16. Annual Notification for Individuals on WWL FY24 Update and Quantity Details 9.27.2023
17. FY24 Annual Notification Msg Electronic Providers 9.1.2023
18. FY24 Annual Notification Msg Electronic Public 9.1.2023
19. FY24 Cover Letter 8.18.2023
20. FY24 IFSP First Steps 8.31.2023
21. FY24 WWL Form and IFSP Survey Postcard 8.18.2023
22. DD Support Coordination Handbook Update 9.1.2023
23. DR0018 Count Of Individuals On Waitlist 8.29.23
24. IFSP FY 2023 Satisfaction Survey Flowchart 8.11.2023
25. IFSP FY 23 Annual Survey 10.13.23
26. Virginia Informed Choice Form and Protocol Update 8.29.23
27. WAIVER WELCOME LETTER TEMPLATE 8.31.23
28. Quarter1 Report FY2024 10.12.23
29. F2F Quarterly Report April 1 - June 30, 2023
30. F2F Quarterly Report July 1 - 9 30. 2023
31. Peer Mentoring Quarterly Report 7.2023-9.2023
32. Peer Mentoring Quarterly Report April 1 - June 20 2023
33. The Arc of Virginia Peer to Peer 720-4798 Renewal 3 of 3, Contract Modification 04 5.11.2023
34. VCU F2F 720-4671 Contract Modification 06 6.16.2023
35. 1IFSP Outreach Materials VER 002
36. DS IFSP ANNUAL STSFCTN SRVY DATA VRFCTN VER 002 7.27.23
37. IFSP F2F P2P VER 003 10.12.23
38. IFSP Funding Attachment B 10.2.2023.
39. IFSP Satisfaction Survey Attachment B 10.2.2023
40. IFSP F2F and P2P Attachment B 10.16.2023.
41. IFSP Outreach Materials VER 002 DR0025 S
42. DR135 Bi-Weekly Waiver Report SQL code 8.7.23
43. DR135 Bi-Weekly Waiver Report SQL code 8.7.23

# APPENDIX B

## Case Management

**by**

**Kathryn du Pree, MPS**
**Joseph Marafito, MS**

# Case Management
# 23rd Review Period
# Study Report

## Introduction

This report constitutes the sixth review of the Compliance Indicators (CIs) for Case Management services. The 22nd Period study showed the achievement of fourteen (74%) of the nineteen CIs reviewed. The difficulties around the remaining five (5) indicators still relate to CSB effectiveness achieving expectations for case management performance on ten elements of the SCQR and DBHDS's ability to achieve the indicator metrics statewide.

The focus of the review in the 23rd review period, is to determine if the Commonwealth has achieved the Case Management CIs that have not been met in the previous two consecutive reviews. The Parties have agreed upon the indicators to determine compliance with Case Management Provisions that remain out of compliance. These include CIs that relate to Provisions III.C.5.b.i., V.F.4, and V.F.5. For this subset of these Provisions, progress toward achieving the agreed upon CI metrics will be reviewed and reported.

This review will include an analysis and reporting of Virginia's status implementing only the CI requirements regarding Case Management that have not been met twice consecutively (see Table below). This includes *CIs 2.2, 2.3, 2.5, 2.16 (including 2.6-2.15), 2.18, 2.20, 46.1, 46.2, and 47.1. The review will determine whether the Commonwealth has sustained its achievement of CIs 2.2, 2.5, 46.1 and 46.2* which were met for the first time during the 22nd review period.

For this report the documents reviewed are identified in Attachment A and most can be located in the DBHDS Team library. This reviewer conducted an interview with Eric Williams, Director of Provider Development/Case Management Steering Committee (CMSC) Chair and Christi Lambert, DBHDS Quality Improvement Specialist with the Office of Community Quality Improvement, in October.

## Summary of Findings for the 23rd Period

In this reporting period the Commonwealth met seven of the nine indicators reviewed. Of the CIs that were met during the 23rd period, *CIs 2.3, 2.18 and 2.20* were met for the first time. *CIs 2.2, 2.5, 46.1, and 46.2* were met and this achievement was sustained for two consecutive periods. *CIs 2.16, and 47.1* remain not met.

The CMSC reviewed the results of the SCQR-FY23 and determined for CY22 records that 64% (307/479) achieved a minimum of nine of the ten indicators, which is below the

benchmark of 86%. This represents a continuing steady improvement over the 42% achievement found in the CY20 records and the 53% achievement found in the CY21 records. Across records five of the ten indicators were above 86%; four were very close; and only one was well below. The indicator, which was significantly below the 86% benchmark was at 54%, requires that ISPs have specific measurable outcomes.

Across CSBs, ten (25%) of the forty CSBs achieved at the 86% benchmark level or better. These results indicate improvement in that four (10%) CSBs met the benchmark for CY21 records versus three (7.5%) meeting the benchmark for CY20 records. However, these findings continue to highlight the large number and percentage of CSBs that are not in compliance.

The CSB response rate for the SCQR-FY23 was again 100% thereby assuring data integrity for sample size. Additionally, the 69% rate of inter-rater agreement between CSB supervisors and the OCQI (Office of Community Quality Improvement) external reviewers is evidence that supervisors are better equipped to determine whether their case managers' records meet Departmental expectations. This improvement is the goal for the SCQR process, and the technical assistance provided by DBHDS.

The SCQR-FY23 made improvements to the process to enhance the applicability of the SCQR by adding children to the sample, revising employment and community integration questions, adding employment discussion questions for ages 14-17, and clarifying guidance for several questions based on user feedback.

The Case Management Steering Committee (CMSC) continued to monitor the CSBs for eleven Performance Indicators (PMI) and eight additional indicators. The minutes of the monthly meetings that occurred between January and June 2023 provide evidence of regular and meaningful involvement of the CMSC in the oversight of the CSBs and DBHDS' implementation of quality review, analysis, technical assistance, training, communication with CSBs, and with the Commissioner's Office for follow through on performance expectations of CSBs. #17).

Finally, no CSB in this cycle underperformed following SCQR technical assistance. Therefore, no enforcement actions were required. During the previous review period, the CMSC recommended one CSB to the Commissioner for a CAP under their Performance Contract for failing to meet targets under other compliance indicators (RST referrals). This CAP was lifted during FY23 as a result of improved performance by the CSB.

**Data Process and Attestation**

**Process Document Review:** The requirements of *CI 2.16* has now been added to DD CMSC DATA REVIEW VER 0011 (#20). The CMSC will analyze the Case Management Quality Review data submitted to DBHDS that report CSB case management performance quarterly. Based on recommendations from the Independent Reviewer (IR) regarding the inability of the Support Coordinator (SC) to assess change in status on the ISP, the Office of Provider Development (OPD) worked with the Independent Reviewer (IR) to define the terms and develop a train-the-trainer model designed to improve consistency in the understanding

and application of these elements of review. This process document also applies to *CIs 46.1, 46.2 and 47.1* as well as a number of other CIs.

The Control Point is clear, concise and monitored throughout the process. Power BI Quarterly Reports were submitted to me for review. They were as follows: DW 126 Targeted Case Management (# 22), DW 126 Enhanced Case Management 128 (# 23) and DW 135 CSB Case Management (# 24). The process of cleaning data before entering into Power BI was also reviewed through a live tutorial as well as using Power BI to verify the process DBHDS uses**.** The Technical Assistance (TA) to CSB personnel responsible for submitting data via CCS3 and using Power BI was also provided to me in a live tutorial. In addition, I viewed the training video for using the TA process and tracking tool.

Documentation for *CIs 46.1 and 46.2* was reviewed for case management contacts (CCS3 Metrics, Look Behinds, WaMS) in the 22nd period. Now for three review periods DBHDS has implemented a Data Quality Framework to review and verify a sample of CSB contact data each quarter and provide follow-up technical assistance. Technical assistance is given on an ongoing basis upon request or upon the discovery of an error. No data from CCS3 are entered into WaMS until they are cleaned therefore eliminating dirty data from CCS3 ever entering Power BI. This process includes a Data Quality Tool to assess sources of data error, a Root Cause Analysis format to assist CSBs in addressing data problems, and ECM educational materials. DQV recognizes that CCS3 is unreliable and has in place a reliable and working mitigation strategy until CCS3 is sun-setted in FY2024.

**Data Set Attestation**. The Commonwealth submitted signed attestations by the Chief Information Officer (CIO) dated 3/4/22 (#18), 9/5/23 (# 19) and 10/16/23 (# 21)

Documentation for *CIs 2.16 and 47.1* (#18) were reviewed in the previous review period. The Chief Information Officer (CIO )found those processes to be thorough and detailed. However, the Attestation still needed to be updated to address issues raised in that 2022 review. The form signed and submitted for review is dated 10/16/23 and has been appropriately updated (#21). It addresses *CIs 2.2, 2.16, 6.2, 6.4 and 47.1.*

Data Set Attestations (#19) for *CIs 46.1 and 46.2* were reviewed. The CIO found both targeted and enhanced case management contact measures to be reliable and valid. Clarification has been provided that the mitigations outlined in the Data Quality Support Process has resolved the DQV data concerns regarding the reliability and validity of CCS3 until being sunset in FY24.

**Conclusion:** All the processes are clear and complete with reliable and valid data. The TA format has solid and verifiable checkpoints and could be a model for other states. All attestations are completed and current.

Table 1 below summarizes the data integrity documents for Process Control Documents and Data Set Attestations.

**Table 1**
**Data Integrity Documents**

| CI | Process Control Document | Data Set Attestation |
|---|---|---|
| 2.16 | DD CMSC DATA REVIEW VER 0011 (process control document- #20) (SCQR Process Documentation (#9), i.e., Methodology) | 2.2 SCQR Process Documentation (#21) |
| 46.1-2 | DD CMSC DATA REVIEW VER 0011 (process control document- #20) | SCQR Data Set Attestation (#19) |
| 47.1 | DD CMSC DATA REVIEW VER 0011 (process control document- #20) | 2.2 SCQR Data Process Documentation (#21) |

**Compliance Indicator Achievement.**

Table 2 below summarizes the status of the case management compliance indicators.

**Table 2**
**Case Management Findings**

| # | Indicator | Facts | Analysis/Conclusions | 22nd | 23rd |
|---|---|---|---|---|---|
| 2.2 | DBHDS will perform a quality review of case management services through CSB case management supervisors/QI specialists, who will conduct a Case Management Quality Review that reviews the bulleted elements listed below. | 2.2 SCQR-FY23 reviewed records from CY22 (#10). This is the fourth year of case management record review using the SCQR and CSB supervisors/QI specialists. | This is the fourth year of case management record review using the SCQR process.<br><br>This indicator continues to be achieved. | **M** | **M** |
| 2.3 | DBHDS will pull an annual statistically significant stratified statewide sample of individuals receiving HCBS waiver services that ensures record reviews of individuals at each CSB. | 2.3 The FY23 SCQR process included revised OSVT guidance; guidance to address employment and ICI questions; and guidance to address employment planning for | 2.3 The FY23 sample included 479 individuals in the sample which included 94 children. The look behind included two children from each CSB with the exception of one | **NM** | **M** |

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| | | 14–17-year-old individuals. These changes were incorporated into the SC Manual and shared with the CSBs (#6,7,8,9)<br><br>This year children were added to the sample. Except for employment questions, the questions for children are the same as for adults. DBHDS did not believe children need to be in a separate group whose numbers independently would be statistically significant. DBHDS did include 96 children in a sample that totaled 479 individuals of whom 383 were adults. The 94 children included 79 coming from the oversample. Past SCQRs have included 400 adults in the sample. | CSB serving only one child. With the addition of children in the sample the Commonwealth has achieved this indicator for the first time. | | |
| 2.5 | DBHDS analysis of the data submitted will allow for review on a statewide and individual CSB level. The Case Management Quality Review will include review of whether the following ten elements are met: | 2.5 SCQR-FY23 reviewed records from CY22. CMSC conducts both statewide and CSB level analysis. This is the fourth year of case management record review using the SCQR, including the ten elements below (#8). | 2..5 This is the fourth year of DBHDS's statewide and individual case management record review of the ten elements using the SCQR. The data submitted allow for review on a statewide and individual CSB level. This CI is now Met for two consecutive periods. | **M** | **M** |
| | 2..6 • The CSB has offered each person the choice of case manager. | 2.6 Compliance reported at 83% (see #13,16). This is compared to 78% in SCQR-FY22 (#12) This is below the benchmark of 86%. | 2.6 See CI 2.16. | | |

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| | 2.7 • The case manager assesses risk, and risk mediation plans are in place as determined by the ISP team. | 2.7 Compliance reported at 88.5%, compared to 84% in SCQR-FY22. This is above the benchmark of 86%. | 2.7 See CI 2.16. | | |
| | 2.8 • 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. | 2.8 Compliance reported at 84%. This is the same performance as in SCQR-FY22. This is slightly below the benchmark of 86%. | 2.8 See CI 2.16. | | |
| | 2.9 • The case manager assists in developing the person's ISP that addresses all the individual's risks, identified needs and preferences. | 2.9 Compliance reported at 84% which is a slight decrease from SCQR FY22. This is slightly below the benchmark of 86% | 2.9 See CI 2.16. | | |
| | 2.10 • The ISP includes specific and measurable outcomes, including evidence that employment goals have been discussed and developed, when applicable. | 2.10 Compliance reported at 54%. This is a significant increase from SCQR-FY22 but substantially below the benchmark of 86%. | 2.10 See CI 2.16. | | |
| | 2.11 • The ISP was developed with professionals and nonprofessionals who provide individualized supports, as well as the individual being served and other persons important to the individual being served. | 2.11 Compliance reported at 88%. This is an increase from SCQR-FY22. This is above the benchmark of 86%. | 2.11 See CI 2.16. | | |
| | 2.12. • The ISP includes the necessary services and supports to achieve the outcomes such as medical, social, education, transportation, housing, nutritional, therapeutic, | 2.12 Compliance reported at 98.5%. This is a slight improvement over SCQR-FY22. This is above the benchmark of 86%. | 2.12 See CI 2.16. | | |

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| | behavioral, psychiatric, nursing, personal care, respite, and other services necessary.<br><br>2.13 • Individuals have been offered choice of providers for each service.<br><br>2.14 • The case manager completes face-to-face assessments that the individual's ISP is being implemented appropriately and remains appropriate to the individual by meeting their health and safety needs and integration preferences.<br><br>2.15 • The CSB has in place and the case manager has utilized where necessary, established strategies for solving conflict or disagreement within the process of developing or revising ISPs, and addressing changes in individual needs, including, but not limited to, reconvening the planning team as necessary to meet individual needs. | 2.13 Compliance reported at 93%. This is a slight improvement over SCQR-FY22. This is above benchmark of 86%.<br><br>2.14 Compliance reported at 84%. This is comparable to the performance on SCQR-FY22. This is slightly below the benchmark of 86%.<br><br>2.15 Compliance reported at 100%. This is the same as SCQR-FY22. This is above the benchmark of 86%. | 2.13 See CI 2.16.<br><br>2.14 See CI 2.16.<br><br>2.15 See CI 2.16. | | |
| 2.16 | The Case Management Steering Committee will analyze the Case Management Quality Review data submitted to DBHDS that reports on CSB case management performance each quarter. In this analysis 86% of the records reviewed across the state will be in implementation with a minimum of 9 of the | The CMSC has reviewed the results of the SCQR FY23 (#15) and determined for CY22 records that 64% of the records achieved at a minimum nine of the ten indicators, which is below the benchmark of 86%. This is an improvement on the 53% metric for the | These results indicate improvement, e.g., ten CSBs meeting the benchmark in CY22 compared to six CSBs meeting the benchmark for CY21 records, and three CSBs meeting the benchmark for CY20 records; 64% of 479 records compared to 53% of 400 records | **NM** | **NM** |

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| | elements assessed in the review. | previous reporting period. There was a decrease in compliance for Indicators 6 and 9 There was an increase in compliance for Indicators 1, 2, 3, 7 and 10. There continued to be 100% compliance for Indicator 5.<br><br>The DD CMSC data review process document (#20) and the SCQR Process Documentation (see #21) were reviewed for case management performance on the ten elements in the compliance indicators and the Look Behind sub-sample review. The FY 2023 SCQR Final Report DRAFT (#16) provides the results on the 10 indicators, the look behind and OCQI Interrater performance. The Maxwell RE coefficient is used for scoring. Moderate agreement ranges from .40 to .59 and Substantial Agreement ranges from .60 to 1. Within the Indicator, area 7 of 10 were within the substantial range and 1 of those in the moderate range. Within the Interrater area, 9 of 10 were in the substantial range and one in the moderate range.<br><br>The requirements of *CI 2.16* have now been | achieving at 86%, and 42% in CY20. However, they also highlight the large amount of CSB underperformance to be corrected.<br><br>DBHDS has taken action to clarify its expectations of Case Managers regarding the content of employment discussions and the requirement to set measurable goals for adults who are interested in pursuing employment or who need education regarding employment to make an informed decision. DBHDS should ensure training in this area for all newly hired Case Managers within ninety days of employment. DBHDS should require an improvement plan for any CSB not yet achieving 86% compliance with phased expectations for improvement if the CSB is significantly below the 86% metric. DBHDS should require and provide technical assistance to any CSB that does not begin to demonstrate improvement within six months to meet CI 2.10.<br><br>The process is reliable and valid and the SCQR | | |

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| | | added to this process document. Therefore it is now in the form of a "process document" and fits the definition of a process. The SCQR Process Documentation Attestation uses the format of a short research paper supplying methodology, information regarding inter-rater reliability information, look behind data, discussion of results and direction for further improvement. While it is more descriptive than the typical attestation it verifies the process as reliable and valid.<br><br>The SCQR Process Documentation (methodology) has now had four complete cycles of implementation and has shown its value as a measurement for CSB case management effectiveness. | Process look behind and inter-rater reliability check is sufficient.<br><br>The Commonwealth has not yet achieved this indicator because only 64% of the records reviewed achieved the benchmark.<br><br>. | | |
| *2.18* | If, after receiving technical assistance, a CSB does not demonstrate improvement, the Case Management Steering Committee will make recommendations to the Commissioner for enforcement actions pursuant to the CSB Performance Contract and licensing regulations. | DBHDS continues to provide targeted technical assistance to CSBs who underperform on three or more of the ten indicators following look-behinds. Ten (25%) CSBs had only 1 indicator below 86%. Eight CSBs had less than 50% of their records with nine of ten indicators meeting the metric of 86%; and 3 or more indicators below 50%. These CSBs received targeted TA. | DBHDS through the CMSC, performs analysis and provides technical assistance to CSBs to improve performance and quality.<br>The Commissioner took an enforcement action (i.e. the requirement of a CAP) for a CSB under the Performance Contract). This CSB was offered and received technical assistance which is part of the quality | **NM** | **M** |

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| | | (#11) No CSBs in this cycle underperformed following technical assistance, so no enforcement actions were required (#5)). DBHDS issued a Corrective Action Plan (CAP) to Hampton Newport News CSB in the 22nd period for 4/15/23-3/31/24 outlining specific expectations (#1). TA and training were offered and documented on three occasions (#4,5). HNN exceeded targets in FY23 Q4 and the CAP was resolved. CSB RST IP Update (#2) indicates ongoing monitoring by DBHDS for RST referrals. | improvement process. The CSB improved its performance, and the CAP was resolved. Therefore, Virginia has fulfilled this indicator's requirements and has been rated as Met for the first time. | | |
| *2.20* | All elements assessed via the Case Management Quality Review are incorporated into the DMAS DD Waiver or DBHDS licensing regulations. Corrective actions for cited regulatory non-implementation will be tracked to ensure remediation. | DBHDS meets quarterly with DMAS-QMR to share and track citations relating to the SCQR elements (see #11). They have cross-walked and tracked actions jointly since 1/23 (#15) The elements identified requiring corrective action are incorporated into the DMAS Waivers or DBHDS licensing regulations. The action plans to address corrective actions are shared with DMAS. There are currently nine CSBs with accepted Improvement Plans and one CSB whose plan is pending as remediation meeting took place in 7/23. | The Commonwealth has now met this indicator's requirements. DBHDS and DMAS have instituted joint tracking of CAPs, which they now call Improvement Plans (IP). This process is in its second year. Virginia has demonstrated remediation for a full review period**.** | **NM** | **M** |

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| 46.1 | The Commonwealth tracks the number, type, and frequency of case management contacts. DBHDS will establish a process to review a sample of data each quarter to determine reliability and provide technical assistance to CSBs as needed. | For the last four review cycles DBHDS has been reviewing and analyzing case management data quarter to quarter (see #15-16) pursuant to a Data Quality Support process (#23-24) that details sample selection, data to be entered, and verification steps. The end goal is a collaborative root cause analysis/TA with CSB staff to resolve data reporting issues by cross-tabbing the CCS3-WaMS-EHR. No data from CCS3 is entered into WaMS until it is cleaned therefore eliminating dirty data from CCS3 ever entering Power BI. Once in Power BI no CSB can change the entries by mistake or intentionally.<br><br>Power BI data were reviewed for case management contacts (#22,23,24). DBHDS has implemented a Data Quality Framework to review and verify a sample of CSB contact data each quarter and provide follow-up technical assistance. This process includes a Data Quality Tool to assess sources of data error, a Root Cause Analysis format to assist CSBs in addressing data problems, and ECM educational materials. DQV continues to deem CCS3 data 'not valid', but has a mitigation strategy in place that addresses | DBHDS has implemented this process for four review periods. Since the 20th review period, all 40 CSBs were reviewed to identify barriers to accurate coding and develop quality improvement plans to ensure case management data are reported accurately. This was followed up with visits at CSBs between DBHDS IT staff and CSB staff to examine 3 records per CSB for accuracy in case management data. This process is in place and will continue in the future.<br><br>The process is reliable and valid and the SCQR Process look behind and inter-rater reliability check is sufficient.<br><br>This CI is now met for two consecutive review periods. | **M*** | **M** |

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| | | the weaknesses in CCS3 data. It will be used as the work around until CCS3 sun sets in FY24. With the mitigation in place and working and CCS3 being eliminated the local individual records no longer present an area for ongoing quality improvement.<br><br>Data Set Attestations (#20) for *CIs 46.1 and 46.2* were reviewed and now address the concerns with the CCS3 data raised in the previous study. | | | |
| 46.2 | The data regarding the number, type, and frequency of case management contacts will be included in the Case Management Steering Committee data review. Recommendations to address non-implementation issues with respect to case manager contacts will be provided to the Quality Improvement Committee for consideration of appropriate systemic improvements and to the Commissioner for review of contract performance issues. | DBHDS has an ongoing, established CMSC workgroup (QII) to address the issue of improved face to face contacts (#14-15).<br><br>The CM contact data were included in the CMSC review. The data shows ECM contacts system wide have not met their internal 90% benchmark; the annual, average FY23 contact rate in Q3 and Q4 was 78%, an increase from 72% in the previous reporting period. ( #15). However, the annual average FY23 contact rate for targeted case management (non-ECM) was over 92.5% (#15).<br><br>The CMSC in its most recent semiannual report issued 9/18/23 (#15), | DBHDS has implemented this data collection and distribution process for three review periods under the Data Quality Framework.<br><br>CMSC has continued regular reporting to QIC (#14,15), which has included recommended improvement initiatives.<br><br>The process is reliable and valid and the SCQR Process look behind and inter-rater reliability check is sufficient. (#19)<br><br>This Ci is now met for two consecutive periods. | **M*** | **M** |

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| | | continues to recommend QIIs to the QIC; reviewed 19 indicators including 11 PMIs (see 47.2); updated the ISP (5/23); and completed its joint review process with DMAS QMR. There are 4 active QIIs and 1 regarding ISP compliance that is pending. The CMSC is addressing the timeliness of ECM and TCM responsibilities. A dashboard has been developed in Power BI; CSB staff have been trained to provide more timely data; and monitoring is ongoing. The CMSC is also addressing the requirements placed on SC/CMs to reduce inefficiencies without compromising compliance with state and federal requirements. The CMSC also took a sample of 4 individual records per CSB from CSBs having difficulty with data required to document SC F2F contact.<br><br>DBHDS provided data so that a sample of 94 TA requests initiated by CSBs or by QI Specialists could be reviewed as part of this study. Of the 94 requests I pulled a random sample of 74 requests and did a direct comparison of request date, TA date, resolution and follow up if necessary. 72 of the 74 | | | |

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| | | requests had a completed TA event on the same day as the request with the remaining two completed the next day. A less in-depth review of the remaining 22 requests evidenced the same timely response rate.<br><br>See 46.1 above for a discussion of reliability and validity issues. | | | |
| 47.1 | The Case Management Steering Committee will establish two indicators in each of the areas of health & safety and community integration associated with selected domains in V.D.3 and based on a review of the data submitted from case management monitoring processes. Data indicates 86% implementation with the four indicators. | CMSC has continued to review 19 performance measure indicators (#15) including the six indicators (PMIs) selected by DBHDS. This SCQR, completed in FY23 Q3 and Q4 address the review for CY22 records. The implementation rates from the SCQR were:<br><br>Change in Status (PMI-16 at 84%)<br><br>ISP Implementation (PMI-17 at 84%)<br><br>Relationships (PMI-18 at 90%)<br><br>Choice (PMI-19 based on Indicator 1: 83% and Indicator 2: 93%)<br><br>The CMSC also tracks two additional PMIs:<br><br>Employment Goals (PMI-2 at 27%) | VA is tracking two indicators in the areas of health and safety: ISP implementation and Change in Status, and two in the area of community integration: Relationships and Choice. The two indicators related to health and safety are each performing at 84% which is below the benchmark of 86%. The two indicators related to community integration are performing at 90% and 93% respectively. Since VA has four indicators in the areas of health and safety and community integration and is below the 86% benchmark on two of them, this indicator is not yet Met.<br><br>To achieve the benchmark, DBHDS should require improvement plans and monthly progress reports from each of the underperforming CSBs. | **NM** | **NM** |

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| | | Employment discussion with 14–17-year-old (PMI-3 at 59%)<br><br>CMSC has engaged in crosswalks and discussion about congruence between PMIs, QSR results, and QMR-DMAS audits (#14,15)<br><br>As referenced in the narrative above, the CMSC meets monthly and is engaged in monitoring the delivery of case management services by the CSBs and reviews the direct review, monitoring, technical assistance, training and policy direction issued by DBHDS (#17) | The processes and attestations for *CI 47.1* have been verified in this reporting period. | | |

*Data and reliability issues

Attachment A
Documents Reviewed

1. CAP for Hampton Newport News Board
2. CMSC IP Updates 10/3/23
3. CMSC IP Status Letter 9/25/23 draft
4. WaMS Online Training Invitation
5. Midpoint TA CSB Performance Tracking
6. SCQR 2023: Summary of Changes
7. SCQR Survey instrument and Technical Guidance FY23
8. SCQR Terms and Definitions
9. SCQR Methodology and Supporting Processes
10. CSB SCQR Sample for First and Second Half Reviews
11. CSB Data Indicator Tracker
12. SCQR Annual Report FY22
13. SCQR Results by Question FY23
14. CMSC Semiannual Report FY23 1st and 2nd Quarters
15. CMSC Semiannual Report FY23 3rd and 4th Quarters
16. SCQR FY23 Draft Report
17. CMSC Meeting Minutes: 1.17.23, 2.7.23, 3.7.23, 4.4.23, 5.16.23, 6.6.23
18. DD Support Coordinator Quality Review Process VER 001
19. DD CMSC VER 016
20. DD CMSC Data Review VER 011
21. 2.2 SCQR Process Documentation 1/19/23
22. DW 126 Targeted Case Management Quality Report
23. DW 128 Targeted Case Management Quality Report
24. DW 135 CSB Case Management Data Quality Process

Submitted:
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Joseph Marafito MS
October 29, 2023

# APPENDIX C

## Crisis and Behavioral Services

**by**

**Kathryn du Pree, MPS**
**Joseph Marafito, MS**

**Review of Crisis Services for the Independent Reviewer**
**Twenty Third Review Period**

## Crisis Services, Mobile Crisis, and Crisis Stabilization Review

This review was conducted during the twenty-third review period. The focus of the review was to determine if the Commonwealth achieved compliance with Compliance Indicators (CIs) that have not been met for two consecutive review periods to date. The Parties have agreed upon a number of indicators to determine compliance with crisis services Provisions that remain out of compliance. These include CIs that relate to Provisions III.C.6.i.-iii for Crisis Services; III.C.6.i.i.A. for Mobile Crisis; and III.C.6i.i.i.B., III.C.6.i.i.i.D; and III.c.6.i.i.i.G for Crisis Stabilization. These CIs, which have not been met or sustained, include: *7.8, 7.14, 7.18, 7.19, 7.20, 8.4, 10.4 and 11.1.* These CIs are associated with each of crisis services' main components identified as Prevention, Mobile Crisis and Crisis Stabilization. Prevention is identified in the CIs to include assessment in the home; behavior supports in the home; and the availability of direct support professionals. For this subset of these Provisions, progress toward achieving the agreed upon CI metrics will be reviewed and reported.

DBHDS provided the documents and files that were requested. Attachment A lists the documents that were reviewed for the purposes of determining compliance with the CIs reviewed for study of the 23rd period. Where applicable, this report cites the document # as listed in Attachment A. I also interviewed Nathan Habel, Project Manager; Sharon Bonaventura and Denise Hall, Regional Crisis Systems Managers; and April Dovel, Director of Crisis Services. I appreciate the time these subject matter experts gave to both answering questions and providing all needed documentation and follow-up.

The Independent Reviewer continues to be deeply concerned about the high number of individuals with I/DD whose initial crisis assessment occurs at hospitals rather than in the individuals' homes as expected in *CI 7.8*. A high percentage of these individuals continue to be admitted to psychiatric hospitals rather than utilizing in-home supplemental supports or crisis stabilization services as alternatives to hospitalization. This dynamic results in an increased number of children and adults with I/DD who are admitted to psychiatric hospitals in Virginia rather than receiving the mobile crisis service and crisis stabilization services required by the Agreement.

This concern continues to be borne out reviewing the data submitted by DBHDS for FY23 Q4 and FY24 Q1. During this time period only 40% of crisis assessments took place on the community in FY23 Q4, and 46% in FY24 Q1. These most recent percentages are consistent with the nearly four years of quarterly reports.

***Table 1:***
***The % of individuals who received their initial crisis assessment at home, residential setting, or community setting (non-hospital/CSB location).***

| Date | Percentage |
|---|---|
| FY 2020 Q3 | 46% |
| FY 2020 Q4 | 41% |
| | |
| FY 2021 Q1 | 53% |
| FY 2021 Q2 | 34% |
| FY 2021 Q3 | 35% |
| FY 2021 Q4 | 42% |
| | |
| FY 2022 Q1 | 51% |
| FY 2022 Q2 | 36% |
| FY 2022 Q3 | 40% |
| FY 2022 Q4 | 36% |
| | |
| FY 2023 Q1 | 44% |
| FY 2023 Q2 | 49% |
| FY 2023 Q3 | 37% |
| FY 2023 | 40% |
| | |
| FY 2024 | 46% |

These quarterly percentages indicate that, over nearly a four-year period, the Commonwealth has not increased in the percentage of children and adults who receive crisis assessments at home or other community location. Far too many children and adults continue to be assessed for a crisis at CSB Emergency Departments or hospitals which leads to the predictable increased rate of hospitalizations compared to the rate of hospitalizations for those individuals who receive a crisis assessment in a community setting. The results of these assessments strongly support the Independent Reviewer's and Expert Reviewer's contention that it is essential to provide these assessments in the community including the individual's home setting because it is far more likely the individual will retain this setting and not be hospitalized if the assessment occurs in the community. It is important to note that there are persistent and substantial variations in the percentages between Regions. For example, Region 1 had as few as 0% in the first quarter of FY 23. Whereas Region 3 had 57% during this same quarter.

***Table 2: Crisis Assessments Conducted In Community Settings***

| Date | Average % assessed in community setting | Range | |
|---|---|---|---|
| FY 22 Q4 | 37% | Region 1 20% | Region 3 55% |
| FY 23 Q1 | 44% | Region 1 0% | Region 3 57% |
| FY 23 Q2 | 49% | Region 1 21% | Region 5 62% |
| FY 23 Q3 | 37% | Region 1 19% | Region 3 50% |

During FY23 Q4 and FY24 Q1 the outcomes for individuals who received a crisis assessment in the community were that over 90% of individuals assessed for a crisis in the community retained their setting compared to under 60% who were able to retain their setting after a crisis assessment that occurred in a hospital, or CSB ED These data are depicted in Tables 3 and 4 below.

***Table 3: Results of Crisis Assessments Conducted in Community Locations***

| Time | Remain Home | CTH/CSU | Other | Hospitalized |
|---|---|---|---|---|
| FY23 Q4 | 91% | 4% | 0 | 5% |
| FY24 Q1 | 92% | 3% | 2% | 3% |

| Time | Remain Home | CTH/CSU | Other | Hospitalized |
|---|---|---|---|---|
| FY23 Q4 | 58% | 5% | 3.5% | 33.5% |
| FY24 Q1 | 60.5% | 3% | 5.5% | 31% |

DBHDS convened the Regional Crisis Managers to conduct a GAP analysis and a Root Cause Analysis (RCA) of the lack of compliance to assess children and adults for crisis in community locations (#14). The group identified six overarching causes: source of request; regulations/practices; public relations; transportation; resources and staffing. DBHDS outlined the action steps necessary to address the causes and include embracing national best practices; engagement with key providers and regional trainings to educate stakeholders on available services (#15).

REACH staff can only assess with the emergency staff at the location the ES staff determine will be used for the crisis assessment. To provide adults known to the system with REACH crisis assessments in the residential or other community setting, DBHDS should require CSBs to have ES staff respond in a community setting and to fill vacant staff vacancies in the REACH programs.

Gap analyses and RCAs were also completed on the identification of community residences for individuals who were hospitalized or admitted to CTHs (#15); and the utilization of the children's CTHs (#16) which indicated the distant location and transportation were among the barriers to utilization.

The Expert Reviewer reviewed the Quarterly REACH reports (#4,5,6,7) to determine the status of the Commonwealth's implementation of the systemic changes needed to resolve the obstacles that have previously slowed progress toward achieving the indicator's measure of compliance. DBHDS continues to report and track all aspects of crisis assessment and services performed by the regional REACH programs. Regions continue to meet the overall expectations for timely response to crises. All REACH programs continue to use telehealth and do not respond to all crisis calls in person. There was some increase in face-to-face assessments in FY24 Q1. Regions vary in their in-person response with Regions 3 and 5 conducting more in person assessments. DBHDS explained in the interview that it has set an expectation that REACH staff will no longer perform crisis assessments via telehealth but are expected to attend all crisis assessments in person. DBHDS shared correspondence (#8) from the Region 2 REACH program to the Emergency Service (ES) Departments in the region indicating that all REACH crisis assessments were to be performed in person going forward. DBHDS reported that each REACH program communicated this information differently. However, the Code of Virginia governing hospital screenings allow for these assessments to be conducted using telehealth. The Commonwealth will only have REACH staff participate in an in-person assessment if Virginia's CSB ES or hospital staff are performing the assessment in-person and include the REACH staff.

The Children's and Adult CTH programs were underutilized during both quarters primarily because of staffing shortages. No wait lists are noted but a high number of individuals are still hospitalized after a crisis assessment who might have been able to be stabilized at a CTH if the program was fully available. DBHDS in its reports only identify two individuals who may have averted from hospitalization if a CTH bed was available. During the interview with the subject matter experts, this reviewer discussed the low utilization of the CTHs and the continued hospitalization of individuals with I/DD after a crisis assessment. DBHDS staff report CTH referrals have decreased, and REACH programs find the individuals who are referred have a higher acuity level. In part, DBHDS suggests that the reduction in referrals may be the result of new staff in CSBs, Emergency Services and hospitals, and that these new personnel may be less aware of the REACH program and the availability of the CTHs "to offer a short-term alternative to institutionalization or hospitalization". DBHDS is developing marketing materials to inform new staff of the purpose and availability of the CTH programs throughout the state. Prevention and mobile crisis services continue to be provided and the outcome is that almost all recipients of these services retain their residential setting after participating in other prevention or mobile crisis services.

DBHDS provided the following response regarding the status of the 988-crisis response line. Virginia continues its partnership with 988 within the Commonwealth to provide more robust access to crisis services. Virginia's 988 can now dispatch Mobile Crisis Response teams when an

individual is identified as needing in-person response. DBHDS reports that this allows for expanded access to REACH services throughout the state. The Commonwealth originally expected that using 988 would lead to an increase in the number of crisis assessments that occurred in community settings. The percentage of assessments in the community has remained at approximately the same rate for the two most recent quarters that it has for the previous three years. The most recent quarter is slightly above the averages of the past three years. Table 1 above shows why this increase must be sustained and continue for the next year before it can be cited as a trend that may eventually lead to a significant increase in the number of assessments completed in the community that achieves the benchmark of 86%.

DBHDS reported on the use of the out-of-home prevention homes for children (#4,5). These settings were expected to provide an alternative support to families and therefore reduce hospitalizations for children and be accessible statewide. Three years ago, the Commonwealth awarded contracts to two providers to serve these children but only one provider continues to be operational for the past two years. The other provider does not have sufficient staff to open homes. In addition, the Commonwealth's crisis services system has not made any referrals in the 22nd or 23rd reporting periods to the provider that DBHDS reports has the potential to be operational. DBHDS also reports that this provider is marketing the prevention homes within the crisis services system and working more closely with REACH. Currently only one home is operating which is located in Region 5. The home accepts referrals from all Regions.

DBHDS conducted a Focus Group (#10) to discuss the utilization of these settings whose purpose is to prevent unnecessary hospitalizations for youth with I/DD through 17 years of age. Admission to these homes is envisioned to last for 3-10 days. REACH, CSB, provider staff and family members participated in the Focus Group. The group discussed the barriers to the utilization of this service. A significant barrier is the location (only in two areas) which created distance and transportation challenges to accessibility. Families also noted that it was difficult to use any location that did not afford the opportunity for their children to continue to attend school or continue routine but important clinical services. Providers were concerned about the fiscal stability of the program. Few providers have been interested in providing this service. The provider in the focus group noted that there is greater financial stability operating sponsored residential homes than operating host homes because of the sporadic nature of admissions to the host homes. The group concluded that alternative prevention services should be explored for youth with I/DD that could be more locally available to more individuals and their families.

DBHDS also surveyed families who were referred to or used the Children's CTHs as a result of concerns about underutilization which was expressed by both the Commonwealth and the Department of Justice (DOJ). Surveys were sent to 260 families in July 2023. DBHDS received responses from only ten (4%) families. Most had a positive experience (55.5%). Those families who did not use the CTH cited the need for a higher level of care, the need for updated clinical testing to access the CTH or wanting a summer alternative program. Some families reported that they did not have a safe way to transport their children to the CTH in the midst of a crisis.

Families were also asked what other supports they needed to help prevent or address crises. Families responded that they want overnight or weekend respite, mobile crisis services, and more specialized intensive in-home services. While DBHDS received a low number of responses, their efforts to understand the weaknesses, barriers and challenges to families using ether out of home prevention services or the CTH is a positive step to take corrective actions that are indicated, and to analyze the Commonwealth's strategy or using host homes as a prevention service. Following the focus group discussion, DBHDS designed action steps to improve the CTH admission process and the child and family's experiences using the CTH. DBHDS is rethinking how to use and enhance the local continuum of crisis services to prevent crisis and support families. DBHDS has not met the requirements of CI13.3 since there has been no utilization of the host home. DBHDS should be recognized for analyzing the reasons for this underutilization and determining that the host home model may not be the option that families want to use. During this reporting period the host homes were not used by anyone including those families who live in the Regions where the homes operate.

DBHDS continues to conduct quarterly reviews of the REACH programs (#11, 17,18). These reviews include data review; review of compliance standards and program performance; clinical chart review of selected program participants; review of any previous corrective actions and an in-person interview to discuss clinical improvement. Most of the Regions met all or the majority of the REACH standards. DBHDS reviewers provide feedback on areas that are partially met and expect improvement. A letter (#12) was issued from DBHDS to the Executive Director of the Region 10 CSB to address poor performance of the Region 1 REACH program. This was sent as a result of underperformance, discovered during DBHDS's REACH qualitative reviews. Region 1 submitted an Action Plan to increase REACH responsiveness and access in the region. Much of the corrective action addressed the impact of the staffing shortage the Region is experiencing.

The REACH programs continue to experience significant staffing shortages. Vacancies in the community programs range from 13% for supervisory/clinical positions to 47% for mobile crisis support workers. The Children and Adult CTH programs experience vacancies as well. The Adult CTH programs overall have 32% of the positions vacant. The Children's CTH and the Adult Transition Homes have fewer vacancies, 14% and 11% respectively. The DBHDS REACH Quarterly Reports note that the CTH program cannot be fully utilized. However, all CTHs have returned to operating with six beds after periods of reduction in the number of beds available in recent reporting periods.

The following Tables depicts the data.

***Table 5: FY23 Annual REACH Staffing Data for REACH Crisis Teams***

| **Position** | **RI** | **RII** | **RIII** | **RIV** | **RV** | **Total** |
|---|---|---|---|---|---|---|
| Supervisory/clinical filled | 6 | 12 | 18 | 16 | 8 | **60** |
| Supervisory/clinical vacant | 1 | 0 | 1 | 1 | 6 | **9** |
| Total | 7 | 12 | 19 | 17 | 14 | **69** |
| Percent Vacant | % | 0% | 5% | 6% | 43% | **13%** |
| | | | | | | |
| Coordinator filled | 6 | 17 | 4 | 13 | 0 | **40** |
| Coordinator vacant | 9 | 7 | 8 | 2 | 0 | **26** |
| Total | 15 | 24 | 12 | 15 | 0 | **66** |
| Percent Vacant | 60% | 29% | 67% | 13% | N/A | **39%** |
| | | | | | | |
| Mobile filled* | 0 | 8 | 6 | 9 | 20 | **43** |
| Mobile vacant | 0 | 0 | 21 | 7 | 10 | **38** |
| Total | 0 | 8 | 27 | 16 | 30 | **81** |
| Percent Vacant | N/A | 0% | 78% | 44% | 33% | **47%** |

- R1 eliminated 2 coordinator positions and has coordinators providing mobile support
- RII added 4 coordinator positions
- R3 continues to have significant vacancies for mobile staff
- R4 added 1 coordinator and added 9 mobile staff
- R5 added 4 mobile staff

***Table 6: FY23 Annual REACH Staffing Analysis for REACH CTH and ATH Settings***

| **Position** | **RI** | **RII** | **RIII** | **RIV** | **RV** | **Total** |
|---|---|---|---|---|---|---|
| Adult CTH filled | 11 | 21 | 22 | 21 | 16 | **91** |
| Adult CTH vacant | 12 | 4 | 7 | 7 | 13 | **43** |
| Total | 23 | 25 | 29 | 28 | 29 | **134** |
| Percent Vacant | 50% | 16% | 24% | 25% | 45% | **32%** |
| | | | | | | |
| Children's CTH filled | | 14 | | 23 | | **37** |
| Children's CTH vacant | | 5 | | 1 | | **6** |
| Total | | 19 | | 24 | | **43** |
| Percent Vacant | | 26% | | 3% | | **14%** |
| | | | | | | |
| ATH Filled | | 18 | | 22 | | **40** |
| ATH Vacant | | 4 | | 1 | | **5** |

| | | | | | | |
|---|---|---|---|---|---|---|
| Total | | 22 | | 23 | | **45** |
| Percentage Vacant | | 18% | | 4% | | **11%** |

- R2 added 2 Adult CTH staff
- R3 added 11 Adult CTH staff
- R4 added 2 Adult CTH staff, decreased 5 Children CTH staff and decreased 5 ATH staff

DBHDS continues to use the Behavioral Support Program Adherence Review Instrument (BSPARI) to determine the quality of the behavior programs developed by behaviorists to provide individuals with therapeutic consultation. The status of these reviews is presented in Table 5. DBHDS is to be commended for developing this comprehensive review process that has achieved high inter-rater reliability. DBHDS BCBAs who conduct these reviews provide feedback and offer assistance to behaviorists to help improve the quality of plans and therefore services individuals with I/DD receive to address problematic behaviors and increase positive behaviors. DBHDS continued activities this year to refine and simplify the scoring methodology, using feedback provided to them by Patrick Heick, the Independent Reviewer's Expert Reviewer during the 22nd review period. This is a clear example of the focus DBHDS places on continuous quality improvement in providing services to individuals with behavioral needs.

**Summary of Findings**

Nine CIs were reviewed in the 23rd period. The Commonwealth met four of these CIs, including *7.14* and *7.20* which are now met for two consecutive periods. Cis *7.19 and 8.4* are now initially met. Virginia has not met CIs *7.8, 7.18, 10.4 (which includes 11.1) or 13.3.* Table 5 summarizes the facts and conclusions for the review of these CIs. All processes and attestations have been verified in previous studies and no substantive changes have been made.

Table 7 below summarizes the status of the Commonwealth's efforts to meet the Crisis Services CIs.

*Table 7: Crisis Services Compliance Indicator Achievements*

| ***SA Provision- 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 induvial from his or her current placement whenever practicable.*** | | | | | |
|---|---|---|---|---|---|
| **#** | **Indicator** | **Facts** | **Analysis/Conclusions** | **22** | **23** |
| 7.8 | 86% of children and adults who are known to the system will receive REACH crisis assessments at home, the residential setting, or other community setting (non-hospital/CSB location). | The following was reported (#2,3) for the percentages of individuals who had a crisis assessment conducted in community settings:<br><br>FY23 Q4 40%<br>Range: 25% R4 to 57% R3<br>DBHDS reported for this quarter the numbers of assessments completed as well as the percentages. A total of 263 assessments were completed of which 106 were conducted in community locations.<br><br>FY24 Q1 46%<br>Range: 29% R1 to 58% R5<br>DBHDS reported for this quarter the numbers of assessments completed as well as the percentages. A total of 330 assessments were completed of which 153 were conducted in community locations. | This is discussed in greater detail in the body of the report but only 42% of all children and adults known to REACH received their crisis assessment in the home or community setting to de-escalate the crisis where it occurred. This percentage aligns with the average annual percentage since FY 2020 and remains far below the performance metric of 86%. Since a higher percentage of individuals are hospitalized when the assessment occurs at either the CSB-ES office or hospital this remains a significant concern. These data are described in the report.<br><br>Virginia has not met this CI's 86% benchmark and remains far below the expected performance metric. | **NM** | **NM** |
| 7.14 | Behavior Supports In Home- By June 2019, DBHDS will increase the number of Positive | DBHDS continues to exceed the goals and measures to increase the number of PBSFs and | The Commonwealth has now met this CIs requirement for two consecutive reporting | **M** | **M** |

| | | | | | |
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| | Behavior Support Facilitators and Licensed Behavior Analysts by 30% over the July 2015 baseline and reassess need by conducting a gap analysis and setting targets and dates to increase the number of consultants needed so that 86% of individuals whose Individualized Services Plan identify Therapeutic Consultation (behavioral support) service as a need are referred for the service (and a provider is identified) within 30 days that the need is identified. | LBAs in the 23rd period (#1). The baseline in FY16 was 821 qualified behaviorists, either PBSFs, LBAs, or LABAs. The increase by FY23 Q3 over FY23 Q1 was 198 for a total of 2802. The FY24 Q1 report documents a further increase to 2906 behaviorists. DBHDS completed a thorough gap analysis the previous review period. | periods.<br><br>. | | |
| 7.18 | Within one year of the effective date of the permanent DD Waiver regulations, 86% of those identified as in need of the Therapeutic Consultation service (behavioral supports) are referred for the service (and a provider is identified) within 30 days. | 854 individuals were authorized for TC (behavioral supports) between 2/-6/23 (#1). Of these individuals 608 (71%) were connected to a behaviorist within 30 days, compared to 358 (66%) of the individuals connected within 30 days in the previous reporting period. Two of the regions, western and northern met the benchmark of 86%. The average number of days for people connected beyond thirty days was 54 (February), 67 (March), 72 (April),68 days (May) and 77 (June). Overall, at the time of the FY24 Q1 report, only 78% of | Overall, only 608 (71%) of the 854 children and adults who were identified for TC were connected to a TC provider within 30 days.<br><br>DBHDS has undertaken a root cause analysis using the Performance Diagnostic Checklist to identify the business problems and identify related solutions. This analysis was conducted by a DBHDS BCBA with subject matter expertise. Potential variables that DBHDS identified as contributing to the Commonwealth's underperformance include Support | **NM** | **NM** |

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| | | individuals who needed a behaviorist were connected to one at all, which is a slight increase over the total number of individuals who were connected in the 22nd period. | Coordinator's (SC's) awareness of the behavioral resources available to individuals in need of therapeutic consultation and the Settlement Agreement requirements; unique CSB business practices; and supervisory support for SCs in this area of performance. DBHDS is providing training, communication and follow up with CSBs regarding expectations and service provider availability.<br><br>To fulfill the requirements of this CI, DBHDS should implement a technical assistance initiative in the three Regions that are underperforming. The TA should be based on the elements of the response systems that are meeting the requirements of this Indicator in the western and northern Regions. These elements include the areas that are contributing to these CSBs current underperformance including Support Coordinator's (SC's) awareness of the behavioral resources available to individuals in need of therapeutic consultation and the | | |

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| | | | Settlement Agreement requirements; unique CSB business practices; and supervisory support for SCs in this area of performance.<br><br>DBHDS has worked to increase the number of providers available in regions following up on last year's gap analysis. A total of 30 providers were added as of 8/23, in 4 of the 5 regions. This ranged from 1 in Central to 18 in the Northern Region. None were added in the Western Region.<br><br>Virginia has continued to not meet this indicator because only 71% of the individuals who need TC are connected to a provider within 30 days. | | |
| 7.19 | 86% of individuals authorized for Therapeutic Consultation Services (behavioral supports) receive, in accordance with the time frames set forth in the DD Waiver Regulations, A) a functional behavior assessment; B) a plan for supports; C) training of family members and providers providing care to the individual in implementing the plan for supports; and D) monitoring of the plan for | DBHDS established its Behavioral Support Program Adherence Review Instrument (BSPARI) to determine whether the four elements of behavioral supports were received (#1).<br>DBHDS reported in the Behavior Supplemental report for FY24 Q1 that 100 behavior plans, and related documentation were reviewed for individuals with annual authorizations for FY23 | The DBHDS Program Manager and the Expert Reviewers agreed to the minimum elements of the BSPARI that needed to be present for a determination that all four requirements of 7.19 were met.<br>This review determined that the DBHDS monitoring process was effectively implemented and was sufficient to identify whether individuals received the four required elements. | **NM** | **M** |

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| | supports that includes data review and plan revision as necessary until the Personal Support Team determines that the Therapeutic Consultation Service is no longer needed. | Q4- FY24 Q1. Eighty-eight (88%) contained all four components of the CI 7.19 requirements, compared to 136 (76%) reported in the 22nd period. | DBHDS reviewed 100 BSPARIs using acceptable criteria for a minimally adequate behavior program and found that 88% contained all four elements. Additionally, DBHDS has reviewed a total of 464 behavior programs. Of these 449 (97%) have been completed prior to or within 180 days of the service authorization. This CI is now achieved. | | |
| 7.20 | DBHDS will implement a quality review and improvement process that tracks authorization for therapeutic consultation services provided by behavior consultants and assesses: (1) the number of children and adults with an identified need for Therapeutic Consultation (behavioral supports) in the ISP assessments as compared to the number of children and adults receiving the service; (2) from among known hospitalized children and adults, the number who have not received services to determine whether more of these individuals could have been diverted if the appropriate community resources, including sufficient CTHs were | DBHDS reported on its quality review and improvement (QI) process for FY22 in the Behavior Supplemental Report (#1). The QI process tracks the authorizations for the number of children and adults needing behavioral services and the number of children and adults receiving behavioral services.<br><br>1) DBHDS reports that 1973 children and adults had a need for therapeutic consultation in FY23 of whom 1558 (79%) received TC. This compares to 1075 children and adults had an identified need for TC, of whom 624 (58%) received TC during the previous year.<br>DBHDS has designed a | This review verified that DBHDS has implemented a QI process that tracks and assesses for the five items listed in the indicator. Virginia has now Met and sustained its achievement of the requirements of this indicator for two consecutive periods.<br><br>1) DBHDS compares the number needing the service to the number receiving the service (not just those authorized). This requirement is achieved because DBHDS compared authorizations to services received.<br><br>2) DBHDS tracks, determines and reports the number of children and adults who could have been diverted. In this period only two are | **M** | **M** |

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| | available; (3) for those who received appropriate behavioral services and are also connected to REACH, determine the reason for hospitalization despite the services; (4) whether behavioral services are adhering to the practice guidelines issued by DBHDS; and (5) whether Case Managers are assessing whether behavioral programming is appropriately implemented. | variety of strategies to increase the number of individuals connected to a provider within 30 days. The strategies are having a positive impact as more individuals are identified as needing TC and a higher percentage are receiving TC.<br><br>2) For FY23 Q3 and Q4 DBHDS reported that 243 individuals were hospitalized and did not have TC accepted REACH services. Two of these individuals could have been diverted from the hospitalization if the CTH was available. Fifty-six individuals who had TC and who were hospitalized accepted REACH services.<br><br>3) DBHDS reports on the reasons the 56 individuals with TC and REACH services were hospitalized. The reasons include suicidality, severe aggression and property destruction, police involvement because of uncontrolled aggression, serious self-injurious behavior, and voluntary admission.<br><br>4) DBHDS implements the BSPARI review which determines if behaviorists are adhering to its | reported who could have been diverted but CTH beds were not available.<br><br>3) DBHDS provides a confidential addendum of the reasons for hospitalization and gives a justification for each of the individuals who were hospitalized. These explanations indicate the need for hospitalization despite the availability of REACH services. DBHDS achieved this requirement.<br><br>4) DBHDS's review through FY23 Q4 through FY24 Q1 120 BSPARIs. The total score for an approved BSPARI is 40 points when all of the practice guidelines are met. DBHDS expects 75% will score at least 30 points and 85% will score at least 34 points. In this period 74% achieved at least 30 points (89 of 120) and 49% achieved 34 of 40 points (59 of 120). The percentage of BSPARIs that reflect the DBHDS expectations increased by 2% from mid FY23 Q3 through FY24 Q1.<br><br>The DBHDS reviewers have provided direct feedback to 73% of the providers in this review | | |

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| | | Practice Guidelines.<br><br>5) DBHDS determined that 74% of the 120 behavioral programming reviews occurring in FY23 Q4-FY24 Q1 were scored correctly on the OSVT compared to the 94 BSPARI reviews that it conducted in FY23 Q2 and Q3, when 64 % were scored correctly. | period.<br><br>The DBHDS monitoring and feedback process continues to demonstrate that it has achieved the requirement to assess whether behavioral services are adhering to the practice guidelines and that it has utilized its findings for performance improvement.<br><br>5) DBHDS also assessed whether CMs were properly implementing the On-Site Visit Tool in their reviews of appropriate behavior services. DBHDS found that the OSVTs were scored correctly by the CM for 74% of the total 120 BSPARI reviews during the entire review period. This is an increase of 12% over the previous reporting period when DBHDS determined that the OSVT were properly completed for 62% of the individuals whose behavior programs were reviewed through BSPARI. The Commonwealth has now achieved and sustained its achievement for two consecutive periods. | | |

| ***SA Provision- III.C.6.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.*** | | | | | |
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| **#** | **Indicator** | **Facts** | **Analysis/Conclusions** | **22** | **23** |
| 8.4 | 86% of initial CEPPs are developed within fifteen days of the assessment. | DBHDS reported (#3) CEPPs completed for FY23 Q4-FY24 Q1 combined. Overall, 87% were completed on time, which is a significant increase from the previous reporting period. This ranged from 81% in R4 to 100% in R1 and R5. | The Commonwealth has now achieved this CI's benchmark. | **NM** | **M** |

| ***SA Provision- 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.*** | | | | | |
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| **#** | **Indicator** | **Facts** | **Analysis/Conclusions** | **22** | **23** |
| 10.4 | 86% of individuals with a DD waiver and known to the REACH system who are admitted to CTH facilities and psychiatric hospitals will have a community residence identified within 30 days of admission. | DBHDS reports separately on those admitted to a CTH and those admitted to a psychiatric hospital (#13). The following data combines these data to evaluate compliance with CI 10.4.<br>In FY23 Q4 a total of 165 individuals were hospitalized or admitted to REACH. A total of 134 (81%) had a community residence identified within 30 days.<br><br>In FY24 Q1 a total of 167 individuals were hospitalized or admitted | In FY23 Q4 and FY24 Q1 only one of the five Regions met or exceeded the 86% expectation. Over both quarters in the 23rd period, 332 individuals were admitted to hospitals and CTHs of which 264 (79.5%) had a community residence identified in 30 days.<br><br>DBHDS should develop, and take other actions needed, to ensure that there are a sufficient number of providers of community based residential services needed by individuals | **NM** | **NM** |

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| | | to REACH. A total of 130 (78%) had a community residence identified within 30 days. | with intense behavioral support needs in each of its five Regions. DBHDS should analyze the practices used in the region meeting this metric and use these practices as the basis for the technical assistance. DBHDS presents combined data for individuals hospitalized and those admitted to REACH CTHs. DBHDS should analyze if there are any significant differences meeting the performance metric between these two groups and if so develop and implement appropriate actions to address the issues causing the variance in performance.<br><br>The Commonwealth has not met the requirements of this Indicator. | | |

| ***SA Provision- 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.*** | | | | | |
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| **#** | **Indicator** | **Facts** | **Analysis/Conclusions** | **22** | **23** |
| 11.1 | 86% of individuals with a DD waiver and known to the REACH system admitted to CTH facilities will have a community residence identified within 30 days of admission. This CI is also in III.C.b.iii.B. | DBHDS reports (#13) that in FY23 Q4 33 individuals were admitted to the CTH who were known to REACH and on a waiver. Of these 26 (79%) had a community residence identified within 30 days of the admission to the CTH. | A total of 58 individuals were admitted to CTHs in this reporting period. Of these individuals 48 (83%) had a community residence identified within 30 days. Region 4 is consistently effective at connecting individuals in the CTH to a community | **NM** | **NM** |

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| | | DBHDS reports (#13) that in FY24 Q1 25 individuals were admitted to the CTH who were known to REACH and on a waiver. Of these 22 (88%) had a community residence identified within 30 days of the admission to the CTH. | provider. The Commonwealth's performance has improved. It has not met the 86% benchmark but has made progress and has come closer to the required performance level. | | |

***SA Provision- 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.***

| # | Indicator | Facts | Analysis/Conclusions | 22 | 23 |
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| 13.3 | The Commonwealth will implement out-of-home crisis therapeutic prevention host-home like services for children connected to the REACH system who are experiencing a behavioral or mental health crisis and would benefit from this service through statewide access in order to prevent institutionalization of children due to behavioral or mental health crises. | The Commonwealth has selected two agencies to provide this support, only one of which is operational as was true in the last reporting period. The home in Region 4 is not operational. The home in Region 5 is considered operational. No children were served during the entire 23rd Review period. Although referrals from across Virginia are accepted, there were no referrals during the 23rd Period. | The Commonwealth has not met the requirements of this indicator. There were no referrals to either of the two programs that created to serve children who would benefit. No individuals have accessed this service during the 23rd Report Period.<br><br>Recognizing that the two homes that DBHDS created are effectively not in operation, DBHDS has reviewed and reported being unsure of the interest among families of children in this model. The distance and transportation challenges are reported to be significant barriers. Appropriately, DBHDS conducted a focus group | **M** | **NM** |

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| | | | during this reporting period to ascertain family interest and concerns. The Focus Group included families, as well as REACH, CBS and provider staff. The DBHDS is planning to develop alternative prevention supports for children based on the lack of utilization of this model and the feedback from the focus group. DBHDS is working with stakeholders to determine alternative approaches that will appeal to more families. DBHDS's alternative may be able to achieve the intent of this CI. | | |

Attachment A
Document List

1. Behavior Supports Report FY24 Q1
2. Supplemental Crisis Report FY23 Q4
3. Supplemental Crisis Report FY24 Q1
4. REACH Data Summary Report-Children: Q4-FY23
5. REACH Data Summary Report- Children Q1-FY24
6. REACH Data Summary Report- Adults: Q4-FY23
7. REACH Data Summary Report- Adults: Q1 FY24
8. Wendy Rose Letter to ES Managers in Region 2: 9.29.23
9. REACH Staffing Reports for FY24Q1: Region 1; 2; 3; 4; 5
10. Focus Group Out of Home Short Term Crisis Prevention for Youth 9.21.23
11. REACH Crisis Services Quarterly Qualitative Review Process
12. DBHDS Assistant Commissioner Gleason Letter to Region 1: 7.24.23
13. Email from Sharon Bonaventura 10.18.23
14. Assessments Completed in the Community- GAP and Root Cause Analyses 5.30.23.
15. CTH and Hospital and CTH RCA 8.1.23
16. Utilization of Youth CTH and Related Youth Services 7.31.23
17. FY23 Q4 REACH Quarterly Qualitative Reviews; Regions 1,2,3,4 and ,5
18. FY24 Q1 REACH Quarterly Qualitative Reviews; Regions 1,2,3,4, and 5

Submitted by:
Kathryn du Pree MPS
October 31, 2023

# APPENDIX D

## Integrated Day Activities and Supported Employment

**by**

**Kathryn du Pree, MPS**
**Joseph Marafito, MS**

**Integrated Day Activities Including Supported Employment for the Independent Reviewer**
**Twenty-Second and Twenty-Third Review Periods**

The purpose of this study is to review the Commonwealth of Virginia's progress achieving the Settlement Agreement's (SA) Compliance Indicators (CIs) for Integrated Day Activities including Supported Employment (Section III.C.7.a. and b.) during the 22nd and 23rd periods. Integrated Day Activities was last studied in the 21st review period. This study will review evidence that the Commonwealth has met CIs *14.8, 14.9* and *14.10* and has completed a legitimate process that verifies the accuracy of the Commonwealth's data and documentation to comply with the related CIs. These CIs have not been Met for two consecutive review periods and are therefore the focus of this review which will analyze the Commonwealth's performance in the twenty-second and twenty-third periods. The other CIs 14.2-14.7 were also Not Met during the previous two consecutive review periods but were removed from monitoring by the Independent Reviewer as a result of an agreement between the Parties and an order by the Court.

Facts were gathered regarding the Commonwealth's progress related to the Compliance Indicators associated with the SA provisions III.C.7.a. The focus for the provisions studied will be to review the Commonwealth's progress toward achieving the indicators to meet employment targets and to increase the service authorizations for integrated days services including employment for adults ages 18-64.

**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 CIs associated with Provisions III.C.7.a. that Virginia has not met twice consecutively and, therefore, were reviewed include:

*CI14.8* New Waiver Targets established by DBHDS's Employment First Advisory Group. The data target for FY20 is 936 individuals in Individual Supported Employment (ISE) and 550 individuals in Group Supported Employment (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.

*CI14.9* The Commonwealth has established an overall target of employment of 25% of the combined total of adults ages18-64 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).

**Methodology**: We engaged in the following activities to review and analyze the DBHDS' progress toward meeting the CIs for integrated day activities. This review focused on the Commonwealth's progress toward achieving the indicators for increasing the number of individuals who are engaged in supported employment or who are competitively employed, and those who are receiving Community Engagement (CE) and other integrated day services. We reviewed the methodology that DBHDS is using to determine that its documents and reports include reliable and valid data only, that the data align fully with all CIs for integrated day activities including supported employment, and that the specific steps that it used to supply a reliable numerator and denominator for calculation that are correct and valid. DBHDS shared its annual assessments of the data sources; the identification of any threats to data integrity; any DBHDS workplans/progress reports to correct data quality problems; the methodology utilized to verify that newly reported data sets are reliable and valid, and the date of the Commonwealth's attestation that the Process Document was properly completed, that the identified threats have been resolved and that the data reported are reliable and valid; and notifications of workgroups related to CIs: *14.8-14.10.*

I interviewed members of the Employment First Advisory Group (E1AG). The E1AG meets bi-monthly and has met regularly in the 22nd and 23rd review periods (#5,6). The E1AG returned to meeting in person in July 2023. The E1AG members who were interviewed are generally positive about the direction of the E1AG. The advisory group is redefining the work of its sub-committees and completing an updated strategic plan. There has been a renewed focus on reviewing data. Some members advocate that the data be reported in such a way that there can be more in-depth understanding and analysis of the data. This would facilitate the E1AG acting in more of an advisory capacity. All members report that the meetings have been more productive with the involvement of Eric Williams and Heather Norton with the E1AG and the sub-committees.

Members remain concerned with meeting the employment targets. While there are increases in the number of individuals with I/DD who are employed, E1AG members report that the workforce shortage is an obstacle that impacts the providers' abilities to have sufficient job coach capacity to assist all individuals seeking employment in a timely way. E1AG members reported that the rate increases which have supported wage increases are helping providers to recruit more staff although both recruitment and retention remain challenging. For the last two years, it was particularly helpful for providers to know of the increases prior to the fiscal years beginning so they could plan for wage increases with more certainty.

**Documents:** We reviewed the Semiannual Reports on Employment; the Provider Data Summary for the State FY2023; the report detailing the number of individuals who start employment services with a provider within 60 days of being authorized for employment services; the meeting minutes for the Employment First Advisory Group (E1AG) and the Community Engagement Advisory Committee (CEAG); the Community Engagement Strategic Plan; the Employment Services Strategic Plan; Attestations and Processes for *CIs 14.8,9, and 10*; and the Consolidated Employment Spreadsheet CES.

**Summary of Findings for the 22nd and 23rd Period**

As noted above, we were asked to review the Commonwealth's progress meeting the following Compliance Indicators: *14.8, 14.9 and 14.10*. None of these were met in previous studies.

*CI 14.8* It is the responsibility of the E1AG to work with DBHDS to set and review the targets. The E1AG has a data committee which reviews the data at least annually and completes trend analyses. The Commonwealth made progress towards achieving its employment targets though 2019. However, it fell short of achieving the annual increased targets. DBHDS achieved the highest percentage towards meeting its overall employment target in 2019 when it reached 89% of the target it set (1078 employed compared to the target of 1211).

An expected decline in the number of employed waiver participants occurred during the pandemic. The decline was dramatic between 2019 and 2020 (from 1,078 to 715 employed waiver participants). This decline began to turn around in FY22 when 764 individuals on the waiver were employed. The Commonwealth did not meet its target for FY23 of 1,486 waiver participants employed but did achieve employment for 866 of these individuals which was a 13% increase in employment in one year. These data are described separately for the 22nd and 23rd periods in Table 2.

The E1AG met in April 2022 to revise the employment targets. This decision was made after a review and analysis of the impact of the COVID pandemic on employment outcomes for individuals with I/DD in Virginia. The decision was to return to the targets of 2019 for 2022 and those of 2020 for 2023. VA achieved the highest percentage of its target since 2019 (pre-pandemic) when the Commonwealth reached 89% of its target as noted above. *CI 14.8* in not achieved as of the 23rd study period.

*CI 14.9* The data reported is derived from data submitted by the Commonwealth's Employment Service Organizations (ESO) and Department for Aging and Rehabilitative Services (DARS). The data are analyzed by DBHDS and the E1AG. As of this report, there were 21,107 individuals receiving or on the wait list for waiver services during the 23rd period. Of these individuals a total of 4,773 (4,224 in ISE and 549 in GSE) were employed. This represents 23% of the waiver population. This is an increase over the 21st study period but *CI 14.9* is not yet achieved. These data are described separately for the 22nd and 23rd periods in Table 2.

*CI 14.10* The Commonwealth established the baseline for this indicator in 2016 when there were service authorizations for 1,120 individuals with I/DD being served in the most integrated employment and day service settings. For this reporting period the comparison is from 3/31/22 to 3/31/23. In March of 2022, there were 3,096 (19.7%) of 15,691 individuals with I/DD who received waiver services and participated in integrated employment or day services. In March of 2023, a year later, 3,254 (19.9%) of 16,320 individuals with DD were participating in the most integrated settings for employment and day services. The number of waiver participants in integrated day services increased by 158 individuals, and the percentage of waiver participants with service authorizations for integrated day services increased by .2%. These data are only reported through March 2023, which is the end of the 22nd review period. The Commonwealth did not provide data for the 23rd review period because DBHDS compares annually in March of each year. Because the percentage of waiver participants in integrated settings decreased by only

.2%, the Commonwealth again did not meet the *CI 14.10* requirement of an annual increase of 3.5% of waiver participants.

**Data Processes and Attestations**

**Facts:** There is now one Process document for *CIs 14.8 and 14.9***.** The data for the *CIs 14.8* and *14.9* 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 I/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. All weaknesses in four process steps that were pointed out in the previous report have been fixed and there are no inherent weaknesses in the process. Data set validation was performed and methodologies were verified.

**Attestations:** The Commonwealth submitted a signed attestation by the Chief Information Officer dated 9/5/2023.

**Conclusion:** The process is well thought out and provides for reliable and valid data input and analysis.

**Facts:** *CI 14.10* is now combined in one process document along with sixteen other CIs that are named in the Provider Data Summary Process Document. On 8/16/23 language was added to accommodate the discontinuation of the baseline measurement tool and the addition of the Provider Data Summary (PDS) Dashboard. No calculations were changed as the result of the modifications. The Control Point is clear and concise. Data is pulled semiannually. Several updates were added since the last review.

An independent data analyst met with the Data Analyst from the Office of Integrated Support Services to review the related Structured Query Language (SQL) Code. The independent data analyst validated that the information pulled via the SQL code was pulling the intended data within the correct parameters. The data analyst also validated the data determination for percentage increases. Each numerator and denominator were calculated across the years. Percentages, increase, decrease, and trend were validated, cross- checked and confirmed. No errors were found.

**Attestations:** The Commonwealth submitted a signed attestation by the Chief Information Officer dated 8/30/2023.

**Conclusion:** The process is well thought out and provides for reliable and valid data input and analysis. Table 1 below summarizes the documents that were used to make these determinations.

**Table 1**
**Data Integrity Documents**

| CI | Process Control Document | Data Set Attestation |
|---|---|---|
| 14.8 | Employment Services Reporting Ver 003 8/29/2023 (#12) | Employment Services Reporting Ver 003 9/5/2023 (#13) |
| 14.9 | Employment Services Reporting Ver 003 8/29/2023 (#12) | Employment Services Reporting Ver 003 9/5/2023 (#13) |
| 14.10 | Provider Data Summary Ver 011 8/17/2023 (#14) | Provider Data Summary Ver 011 8/30/2023 (#15) |

**Compliance Indicator Achievement**

Table 2 below summarizes the status of the compliance indicators. For integrated day services.

**Table 2**
**Integrated Day Services Findings**

| # | Indicator | Facts | Analysis/Conclusions | 22nd | 23rd |
|---|---|---|---|---|---|
| 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 its targets. | 14.8 The E1AG met in April 2022 to revise the employment targets (#1,2). The E1AG made the decision to lower the targets after it reviewed and analyzed the impact of the COVID pandemic on employment outcomes for individuals with I/DD in Virginia. The targets for 2023 are: 1486 individuals employed overall including 936 in ISE and 550 in GSE.<br><br>The Commonwealth added several hundred individuals to the waiver since FY20.<br><br>During the 22nd period as reported in the Semiannual Employment Report through December 2022, the number of individuals who were employed was 866 of whom 584 were in ISE and 282 were in GSE (#2). This number compares to the target for 2020 of 1486 of whom 936 were targeted for ISE and 550 were targeted for GSE. However, DBHDS does | 14.8 The Commonwealth has increased the number of individuals with waiver-funded services who are employed by 222 (29%) since 2022 when 764 individuals were employed. This is a significant increase and demonstrates that Virginia is trending in a positive direction and recovering employment opportunities and outcomes for individuals with I/DD since the pandemic. While the total number of individuals employed (986) is not the highest number in the Commonwealth's history of 1,078 individuals employed in 2018, the highest number of individuals are now employed in ISE. This is a significant accomplishment. The Commonwealth has always intended to decrease the number of individuals in GSE and increase the number of individuals in ISE.<br><br>The targets for | **NM** | **NM** |

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| | | not set specific targets in six month increments but rather sets the target annually.<br><br>During the 23rd period the number of individuals employed was: 986 overall of whom 702 were in ISE and 284 were in GSE. VA met 66% of its target for 2023. The Commonwealth increased by 222 the number of individuals employed compared to the number employed in 2022. The increase included 172 more individuals employed in ISE and 50 more individuals employed in GSE.<br><br>VA had achieved the highest percentage of its target in 2019 (pre-pandemic) when the Commonwealth reached 89% of its target. (#1) | employment including ISE and GSE were not met so this indicator has not yet been achieved.<br><br>. | | |
| 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. | The data reported are derived from data submitted by the Employment Service Organizations (ESO) and DARS. The data are analyzed by DBHDS and the E1AG (#1,2).<br><br>22nd Period: As of this report, there were 20,642 individuals receiving or | The Settlement Agreement establishes a target of 25% employment for the adults on the I/DD waivers or wait lists. In this reporting period only 23% of this population was employed in ISE or GSE offered by DBHDS or DARS. This is a significant | **NM** | **NM** |

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| | | on the wait list for waiver services. Of these individuals a total of 4,497 (3,933 in ISE and 564 in GSE) were employed. This represents 22% of the waiver population.<br><br>23rd Period: As of this report, there were 21,107 individuals receiving or on the wait list for waiver services. Of these individuals a total of 4,773 (4,224 in ISE and 549 in GSE) were employed. This represents 23% of the waiver population. This is an increase of 191 individuals in ISE since the 22nd Period and an overall increase of 1% toward the goal of 25% of individuals on the waivers or the waiting list being employed.<br><br>These are the 16th and 17th semiannual employment report produced by DBHDS. Data were submitted by 100% of the Employment Service Organizations (ESO) and by DARS in both periods. The individuals employed primarily participate in the Extended Employment Services (EES); Long-term Employment Support Services (LTESS); and HCBS waiver programs. The | accomplishment as the Commonwealth and the nation are rebounding from the COVID pandemic.<br><br>This indicator has not been achieved but the metrics are trending positively. | | |

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| | | E1AG conducts trend analyses for the data in the semiannual employment reports and uses this analysis to make recommendations to DBHDS which are contained in the semiannual reports. | | | |
| 14.10 | DBHDS service authorizations 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).<br><br>. | The baseline for this indicator was established in 2016 when there were service authorizations for 1,120 individuals with I/DD being served in the most integrated employment and day service setting. For this reporting period the comparison is from 3/31/22 to 3/31/23. (#3) In 2022 there were 3,096 (19.7%) of 15,691 individuals with DD who received waiver services who participated in integrated employment or day services. In March of 2023 a year later, 3,254 (19.9%) of 16,320 individuals with DD were participating in the most integrated settings for employment and day services. | Comparing the achievement of the number of service authorizations in March of 2022 to the number in 2023, there is a slight increase of .2% from 19.7% to 19.9%, in the number of these service authorizations. Within the service types that comprise VAs array of integrated day services, there were increases in ISE (13); Workplace Assistance (7) and Community Engagement (183). There were slight decreases in GSE (27) and Community Coaching (8). However, the overall number of individuals participating in some type of waiver day service which includes non-integrated settings, increased by 624 (from 6,396 in March 2022 to 7,020 in March of 2023).<br><br>The Commonwealth has not achieved the requirements of this indicator. | **NM** | **NM** |

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| | | | There are job opportunities for individuals with I/DD but providers continue to be challenged to recruit and retain job coaches. To achieve compliance the Commonwealth should work with the provider community to determine the wages that are necessary to address this systemic problem successfully and provide increased funding rates for its integrated employment and day services to ensure that an increased percentage of individuals with IDD participate in these service options. DBHDS should continue to monitor compliance with CI 2.10. Individuals and families need to see the value of employment; understand the impact on benefits; and want to pursue employment for this indicator to be met. DBHDS should also implement the recommendations of the Community Engagement Advisory Group regarding marketing these integrated day options and training Case Managers, families and individuals about these services so that there is increased participation. | | |

Attachment A
Documents Review
Integrated Day Services- Title or File Name

1. Semiannual Employment Data Report June 2023 Data
2. Semiannual Employment Data Report December 2022 Data
3. Provider Data Summary State FY2023: issued May 2023
4. Community Engagement Work Plan Fy24-26
5. E1AG Plan for FY24-26 with Quarterly Updates
6. E1AG Meeting Agendas and Minutes: 1/23, 2/23, 6/23, 8/23
7. Attestation Employment Data Measures Attachment B-9 5/23
8. Attestation Integrated Day Percentage Increases 8/23
9. Process Document: Employment Services Reporting: CI 14.8, 14.9 8/23
10 Process Document DD Provider Summary Verification 022 8/23
11 Consolidated Employment Spreadsheet (CES) Recommendations Progress 8/23
12 Employment Services Reporting Ver 003 8/29/2023
13 Employment Services Reporting Ver 003 9/5/23
14 Provider Data Summary Ver 011 8/17/2023
15 Provider Data Summary Ver 011 8/30/2023

Submitted by:
Kathryn du Pree MPS
Joseph Marafito MS
October 30, 2023

# APPENDIX E

## Transportation

**by**

**Chris Adams, MS**

**TO:** Donald Fletcher, Independent Reviewer

**FROM:** Chris Adams

**RE:** 23rd Period Study Report: Transportation

**DATE:** October 18, 2023

## Introduction

Prior to initiation of the 23rd study of the requirements at Provision III.C.8.a, the Commonwealth was found to have achieved and sustained achievement of the requirements in the following six Compliance Indicators:

- 16.1 - 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.
- 16.3 – 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.
- 16.4 – b. Ensure DD Waiver users and/or their representatives have opportunities to participate in the regional Advisory Boards; and
- 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.
- 16.6 – 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.
- 16.7 – DMAS provides all Medicaid recipients with information on processes for filing complaints or appeals related to their Medicaid services.

The focus of this current study is on the following two Compliance Indicators. The requirements for Compliance Indicator 16.2 have not previously been achieved and the requirements for Compliance Indicator 16.8 were achieved for the first time during the 21st period study:

- 16.2 – At least 86% of DD Waiver recipients using Medicaid non-emergency medical transportation (NEMT) will have reliable transportation.
- 16.8 – 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 participate in community activities and Medicaid services.

## Summary of Findings - 23rd Study

### Compliance Indicator 16.2:

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 current study of transportation requirements is:

- To determine whether the requirements at Compliance Indicator 16.2 that at least 86% of DD Waiver recipients using Medicaid non-emergency medical transportation (NEMT) have reliable transportation have been achieved and that the data used to measure achievement of the 86% threshold has been determined and verified to be reliable and valid.
- To determine whether achievement of the requirements at Compliance Indicator 16.8 has been sustained and that the data used to measure achievement of the 86% threshold has been determined and verified to be reliable and valid.

In Q2 FY23, DMAS began requiring GPS based technology for drivers and using a 15-minute window on either side of the appointment time as the definition of 'late'. This methodology produces data that is used to measure achievement of the requirements of this Compliance Indicator. Following is an enumeration of the data results for the most recent three quarters using the revised methodology:

- Q2 FY23 - 328,521/379,390 (86.59%) (1st full quarter new methodology)
- Q3 FY23 – 389,982/425,976 (91.55%)
- Q4 FY23 – 398,248/445,071 (89.48%)

### Compliance Indicator 16.8:

The Quality Services Review (QSR) tool utilized by the Health Services Advisory Group (HSAG) in Rounds 4 and 5 of the QSR Person-Centered Review (PCR) includes three questions that relate to transportation. Responses from two of the questions provide quantitative data for analysis and computation of the percentage used for this Compliance Indicator and responses from the third question provide qualitative data to inform future targeted improvement initiatives. The responses from the two quantitative questions are combined into a single percentage score using methodology that is outlined in detail in a process document provided for review in this study.

The percentage of persons who indicated, based on responses to the two transportation-related questions in the QSR review, that they have reliable transportation to participate in community activities and Medicaid services in both Rounds 4 and 5 exceeded the 86% threshold required in this Compliance Indicator. In Round 4, 94.2% of the 343 persons whose interviews resulted in a measurable response to the transportation-related questions indicated they have reliable transportation to participate in community activities and Medicaid services and in Round 5, the percentage was 93.0% of the 334 persons in the sample.

The methodology utilized to factor data from the two transportation-related questions into a single percentage score is sound and produces comparable results for use in determining whether the requirements of this Compliance Indicator are achieved. There was some discussion regarding the decision to omit interviews scored as "Could Not Determine" but the resulting decision to omit these from the denominator calculation appears appropriate. In Round 4 this omitted 74/417 (17.7%) of the sample and in Round 5 72/456 (15.8%). The number of Could Not Determine responses was cited in the data set

validation process as a potential concern, and it was recommended that DBHDS work with the vendor to identify ways to mitigate this, but in the validation report, the data analyst stated that this does not impact the reliability and validity of the data used for this measure.

In summary, during the 22nd study, the Commonwealth achieved the requirements in Compliance Indicator 16.2 and sustained achievement of the requirements in Compliance Indicator 16.8. During the 23rd study, the Commonwealth sustained achievement of the requirements of Compliance Indicators 16.2 and 16.8. No curative actions were associated with this Provision. A more detailed analysis of the findings for this review is summarized in Table 1 below.

## Methodology

Procedures employed by this consultant in previous reviews were continued for this current study. These included reviewing documents and records (see Table 3) to evaluate evidence and substantiate the extent to which the Commonwealth has achieved or sustained achievement of the requirements in Compliance Indicators 16.2 and 16.8. Additionally, this consultant conducted virtual interviews and conversations with staff members knowledgeable about the processes, their implementation, and oversight (see Table 2) to clarify questions regarding the documentary evidence and to offer them additional opportunities to provide any information that would be helpful in reaching a conclusion about indicator achievements. This study also included review of process documents and attestation statements relevant to the data associated with these two Compliance Indicators. This review verified that the processes are well-documented and that the steps in each of the processes were tested by a data analyst who determined that the processes were accurately described and that the data resulting from the processes was reliable and valid.

## Process Documents & Attestations

For Compliance Indicator 16.2, the Commonwealth provided a description of the data retrieval and analysis processes associated with the percentage measurement for this indicator and an attestation statement that describes their methodology for determining whether the process and its resulting data are reliable and valid. Each step in the process is described clearly and in detail and upon replicating the process steps outlined in this document, the data analyst determined the process to be sound and its results to be reliable and valid. This is further supported by the consistency of the data resulting from the process over the three quarters noted in the Summary of Findings section above.

For Compliance Indicator 16.8, the Commonwealth provided a process document that contains a detailed description of the data retrieval and analysis processes associated with the percentage measurement for this Compliance Indicator and an attestation statement that describes their methodology for determining whether the process and its resulting data are reliable and valid. The data reporting and analysis procedures used in the four QSR rounds prior to this calendar year were validated by Data Quality and Visualization staff in 07/2021 and again in 02/2022 with no identified concerns noted from either review. The Director of the DBHDS Office of Clinical Quality Management assessed the QSR process in 2023 and identified no data reliability and validity threats for data used in this measure. The attestation statement provided describes the data analyst's validation procedures and the determination, based on this evaluation, that the data collection, analysis, and reporting processes were reliable and valid.

## Compliance Indicator Achievement

Based on review of relevant documentary evidence, interviews with key staff at DBHDS and DMAS, and verification of data relevant to Compliance Indicators 16.2 and 16.8, there is sufficient evidence to conclude that the Commonwealth achieved the requirements of Compliance Indicator 16.2 in the 22nd review period

and sustained that achievement in the 23rd review period. The requirements for Compliance Indicator 16.8 were achieved in the 21st review period and sustained in the 22nd and 23rd periods. The 22nd and 23rd reviews further verified that process descriptions related to data specific to these indicators are well-documented, and that the resulting data has been determined to be valid and reliable.

Table 1 below details the facts, analysis, and conclusions drawn from the review of the Commonwealth's efforts to achieve and sustain the requirements of Provision II.C.8.a, Compliance Indicators 16.2 and 16.8.

Table 1
Compliance Indicator Table

| 23rd Study Findings |
|---|
| **Provision 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. |

| CI | Facts | Analysis | Conclusion(s) |
|---|---|---|---|
| 16.2:<br>2. At least 86% of DD Waiver recipients using Medicaid non-emergency medical transportation (NEMT) will have reliable transportation. | A new trip-encounter electronic measurement methodology was approved and implemented in 11/2022. Data using this revised methodology has been reported for three consecutive quarters and has resulted in significant improvement in on-time performance exceeding the 86% threshold required by this Compliance Indicator.<br><br>DMAS has worked with NEMT providers and the FFS NEMT broker to refine the data collection, reporting, and analysis processes associated with the revised methodology that was verified and validated by the data analyst using data from 01/2023-03/2023.<br><br>Using the revised methodology implemented in 11/2022, the on-time performance data has been at or above 86% for three consecutive quarters supporting the determination that DD Waiver recipients | A new trip-encounter electronic measurement methodology was negotiated with the IR and approved to be implemented in Q2 FY23 (10/2022-12/2022). Baseline measurement was calculated using Q4 FY22 (04/2022-06/2022) data with the "Total On-Time %" being 199,209/363,258 (54.84%).<br><br>Performance data was documented in the following data reports - ***Q4 FY22 PROGOPS FFS NEMT OTP Report 120122 Final***; ***Q1 FY23 PROGOPS FFS NEMT OTP Report Final***; ***Q2 FY23 PROGOPS FFS NEMT OTP Report Final***; ***Q3 FY23 PROGOPS FFS NEMT OTP Report Final;***; and ***DOJ Compliance Indicator 16.2 Q4 draft – complete Q4 data.***<br><br>Quarterly on-time percentages are as follows:<br>• **21st study period:**<br>  • Q1 FY23 – 187,538/369,913 (50.70%)<br>• **22nd study period:**<br>  • Q2 FY23 – 328,521/379,390 (86.59%) (1st full qtr new methodology)<br>  • Q3 FY23 – 389,982/425,976 (91.55%) | 21st – Not Met<br><br>22nd – Met<br><br>23rd – Met |

| CI | Facts | Analysis | Conclusion(s) |
|---|---|---|---|
| | using NEMT have reliable transportation. | • **23rd study period:**<br>  • Q4 FY23 – 398,248/445,071 (89.48%)<br>Note: There is a one quarter lag in production of this data so Q1 FY24 data will not be available for review in the 23rd study period.<br><br>With the implementation of the electronic measurement methodology, which was determined to be much more reliably accurate, the number of on-time trips significantly increased in Q2 FY23 and has remained at or near the 90% level through three consecutive quarters.<br><br>DMAS attributes the significant improvement in on-time performance to several factors:<br>• The implementation and ongoing refinement of a fully digitized tracking and monitoring system (using GPS) to measure on-time performance.<br>• Outreach meetings with Non-Emergency Medical Transport (NEMT) providers that emphasized the critical importance of consistently and accurately digitizing each trip assigned every time and reminding providers that one consequence of not accurately and consistently using the digital system would be a reduction in the number of trips assigned by the Fee-For-Service (FFS) NEMT broker as a consequence of non-compliance.<br>• Joint efforts by the FFS NEMT broker and DMAS to implement and refine data tracking software and databases that ensure data is accurately and consistently reported each quarter.<br>DMAS continues to work with the | |

| CI | Facts | Analysis | Conclusion(s) |
|---|---|---|---|
| | | FFS NEMT broker to refine the data capturing system and processes and will continue to conduct outreach sessions with NEMT providers during quarterly Provider and Advisory Board meetings to focus attention on timely digitizing trips and the consequences of non-compliance.<br><br>DMAS is also re-procuring the FFS NEMT broker contract and has included additional requirements in the new draft contract regarding the on-time performance data capturing process to stimulate ongoing system refinement and data quality. The Request for Proposals for this re-procurement is scheduled for release in 12/2023 with an anticipated award date in Fall 2024.<br><br>The data retrieval and analysis processes associated with the percentage measurement for this indicator are described in detail in the ***Process Document 16.2 Transportation VER 002*** dated 08/30/2023. The document describes the nine separate data queries that are utilized to extract source data for the measure, the subsequent creation of data summary reports in Excel format, and the integration of this data into the ***Program Operations FFS NEMT On-time Performance (OTP) Report*** in Excel format. The document includes description of changes made in the process on 08/30/2023 to create revised data reporting templates. Each step in the process is described clearly and in detail. The data analyst replicated the processes outlined in the Process Document using data from 01/2023-03/2023 and identified some errors related to manual transfer of data from data | |

| CI | Facts | Analysis | Conclusion(s) |
|---|---|---|---|
| | | spreadsheets to the summary spreadsheet. This manual process was modified and automated which resolved the issue. With this modification, the data analyst verified and validated that the data collection, analysis, and reporting processes were reliable and valid. An Attestation Statement ***16.2 NEMT Transportation Attachment B 9.22.2023*** documents this determination of reliability/validity. Based on evidence presented for this Compliance Indicator, the Commonwealth achieved the requirements in the 22nd review period and sustained that achievement in the 23rd review period. | |
| **16.8:**<br>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 | HSAG's QSR tool includes three questions that relate to transportation. Questions 165 and 166 provide quantitative data for analysis and computation of the percentage used for this Compliance Indicator and Question 167 provides qualitative data to inform future targeted improvement initiatives.<br><br>Data from QSR Rounds 4 and 5 were available for review during this study to quantify whether 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 measurement are as follows:<br>• Round 4 – 94.2%<br>• Round 5 – 93.0%<br>Percentages for both Rounds 4 and 5 exceed the 86% | The Quality Services Review (QSR) tool utilized by the Health Services Advisory Group (HSAG) in Rounds 4 and 5 of the QSR Person-Centered Review (PCR) includes three questions that relate to transportation:<br>*165. If you want to go somewhere, does your provider take you?*<br>*166. Can you get where you want to go without problems?*<br>*167. If "no", what kinds of problems do you have?*<br>Questions 165 and 166 provide quantitative data for analysis and computation of the percentage used for this Compliance Indicator and Question 167 provides qualitative data to inform future targeted improvement initiatives.<br><br>The methodology utilized to factor data from Questions 165 and 166 into a single percentage score is sound and produces comparable results for use in determining whether the requirements of this Compliance Indicator are met. There was some discussion regarding the decision to omit | 21st – Met<br><br>22nd - Met<br><br>23rd - Met |

| CI | Facts | Analysis | Conclusion(s) |
|---|---|---|---|
| the QSR annual report presented to the Quality Improvement Committee (QIC). At least 86% of those reviewed report that they have reliable transportation to participate in community activities and Medicaid services. | threshold required by this Compliance Indicator.<br><br>Data and information from the QSR reviews was presented to the Quality Improvement Committee each quarter as is documented in the ***QIC Review Schedule SFY23.***<br><br>The ***Process Document 16.8 Transportation Non-NEMT Through QSR PCR VER 8*** dated 09/27/2023 provides detailed descriptions of the data reporting, collection, and analysis processes.<br><br>The ***16.8 Provider Transportation Attachment B 9.27.2023*** Attestation Statement verifies that the data reporting, collection, and analysis processes have been determined reliable and valid by the data analyst. | interviews scored as "Could Not Determine" (CND) but the resulting decision to omit these from the denominator calculation appears appropriate. In Round 4 this omitted 74/417 (17.7%) of the sample and in Round 5 72/456 (15.8%). The number of CND interviews was cited in the data set validation process as a potential concern, and it was recommended that DBHDS work with the vendor to identify ways to mitigate this, but in the validation report, the data analyst stated that this does not impact the reliability and validity of the data used for this measure.<br><br>The results of the two most recent QSR PCR reviews reported in the ***Provider Transportation Summary QSR Round 5 Update 9.1.2023*** are:<br><br>• <u>Round 4 (22nd review):</u><br>• **Denominator:** 417 persons interviewed – 74 CND responses = 343<br>• **Numerator:** 339 Q165 YES responses – 16 Q166 NO responses = 323<br>• **Calculated percentage 323/343 = 94.2%**<br><br>• <u>Round 5 (23rd review):</u><br>• **Denominator:** 456 persons interviewed – 72 CND responses = 384<br>• **Numerator:** 376 Q165 YES responses – 19 Q166 NO responses = 357<br>• **Calculated percentage 357/384 = 93.0%**<br>The denominator for each of these rounds omits CND responses for Q165.<br><br>Data and information from the QSR reviews is presented to the | |

| CI | Facts | Analysis | Conclusion(s) |
|---|---|---|---|
| | | Quality Improvement Committee each quarter as is documented in the ***QIC Review Schedule SFY23*** and the minutes and materials of the QIC meetings on 09/21/22, 12/12/2022, 03/27/2023, and 06/26/2023.<br><br>The data retrieval and analysis processes associated with the percentage measurement for this indicator are described in detail in the ***Process Document 16.8 Transportation Non-NEMT Through QSR PCR VER 8*** dated 09/27/2023. The Process Document describes data reporting from HSAG, and the data calculation steps completed by the DBHDS QSR Reviewer to combine data from Questions 165 and 166 into a single score. The data reporting and analysis procedures used in the four QSR rounds prior to this calendar year were validated by Data Quality and Visualization staff in 07/2021 and again in 02/2022 with no identified concerns noted from either review. The Director of the Office of Clinical Quality Management assessed the QSR process in 2023 and identified no data reliability and validity threats for data used in this measure. Some modifications to the data query procedures were made for data analysis refinement in Rounds 4 and 5 in 2023. The data analyst reviewed the modified processes subsequent to these changes being made, tested each step in the process, and conducted cross checks. A few minor concerns were identified and immediately remedied, and the data analyst was able to verify and validate that the data collection, analysis, and reporting processes were reliable and valid. An | |

| CI | Facts | Analysis | Conclusion(s) |
|---|---|---|---|
| | | Attestation Statement *16.8 Provider Transportation Attachment B 9.27.2023* documents this determination of reliability/validity.<br><br>Based on evidence presented for this Compliance Indicator, the Commonwealth achieved the requirements in the 21st review period and sustained that achievement through the 22nd and 23rd review periods. | |

**Recommendation:**

1. Consistent with a recommendation documented in the Process Document for Compliance Indicator 16.8, DBHDS should work with the QSR vendor to identify ways to reduce the number of interviews resulting in a "Could Not Determine" response and this data point should be tracked to ensure that process improvement efforts achieve the desired reduction in this percentage over time.

Table 2

Interviews Conducted

The Consultant conducted telephonic interviews or interviews through email correspondence with the following staff members knowledgeable about the processes relevant to the Compliance Indicators that are the focus of this study to clarify questions regarding the documentary evidence and to afford them additional opportunities to provide any information that would be helpful in reaching a conclusion about indicator achievements.

| Name | Title |
|---|---|
| Ann Bevan | Director, High Needs Support Division, DMAS |
| Heather Norton | Assistant Commissioner, Developmental Services, DBHDS |

Table 3
Documents and Records Reviewed

1. Q4 FY22 PROGOPS FFS NEMT OTP Report 120122 Final
2. Q1 FY23 PROGOPS FFS NEMT OTP Report Final
3. Q2 FY23 PROGOPS FFS NEMT OTP Report Final
4. Q3 FY23 PROGOPS FFS NEMT OTP Report Final
5. DOJ Compliance Indicator 16.2 Q4 draft – complete Q4 data
6. QIC Review Schedule SFY23
7. 9.21.22 QIC Materials and Minutes (includes the QSR Report to the QIC)
8. 12.12.22 QIC Materials and Minutes (includes the QSR Report to the QIC)
9. 3.27.23 QIC Materials and Minutes (includes the QSR Report to the QIC)
10. 6.26.23 QIC Materials and Minutes (includes the QSR Report to the QIC)
11. NEMT OTP Summary Ad Hoc Report for 23rd Pd Study
12. DMAS NEMT document production 23rd period v09523
13. DMAS Doc Production 2023 Transportation Study 23rd Review Period V2
14. 221113 DMAS Trans NEMT Final encounter performance measure
15. Contract 10041 Mod 5 OY Renewal 3 fully executed
16. VA Transportation Provider Manual 030818 (4)
17. Process Document 16.2 Transportation VER 002
18. Program Operations FFS NEMT On-Time Performance (OTP) Report
19. NEMT Transportation Attachment B 9.22.2023

# APPENDIX F

## Community Living Options

**by**

**Kathryn du Pree, MPS**

**Community Living Options Report**
**23rd Review Period**
**Prepared for the Independent Reviewer**

## Introduction

This report constitutes the fifth review of the compliance indicators for Community Living Options (Integrated Settings - Section III.D.1). In the Independent Reviewer's 22nd Report to the Court, the Commonwealth provided documentation that twenty (20) of twenty-three (23) indicators (87%) had been achieved, of which seventeen (17) were met for two consecutive study periods.

This fifth review being conducted during the 23rd review period is to determine if the Commonwealth has achieved compliance with the Compliance Indicators (CIs) that have not been met for two consecutive review periods. This includes the following CIs which were met for the first time in the 22nd review period: *CIs 18.3, 18.4* and *18.5* to determine if achievement has been sustained; and those CIs which have not been met in any review period since the Indicators were established in FY 2020: *CIs 18.2, 18.6 and 18.9.*

For this review the facts gathered are identified and analyzed for each indicator in the Findings Table below. The documents which include these facts are listed by reference in Attachment A and most are found in the Commonwealth's Team library. Clarifying interviews were conducted with DBHDS manager Eric Williams, Director of the Office of Provider Development, and Christi Lambert Quality Improvement Specialist, Office of Community Quality Improvement.

## Summary of Findings for the 23rd Review Period

This review found that five of the six indicators (87%) reviewed were newly achieved or had been sustained through continuing effort. *CIs 18.2 and 18.6* were achieved for the first time in the 23rd review period. *CIs 18.3, 18.4 and 18.5* have now been met for two consecutive reporting periods. The remaining indicator *CI 18.9* addresses the delivery of nursing services to both children and adults. This CI remains not met.

DBHDS data showed that market share of authorizations for individuals being served in integrated residential settings has continued to grow as a percentage of all residential settings, i.e., 79.4% in 2016 to 90% in 2023. Data showed a 2.3% increase between 3.31.22 and 3.31.23, which exceeds the 2% benchmark for the first time. This compliance indicator metric has consistently trended in a positive direction (never below 1.2%).

The baseline was set 9.30.16. Since then, the Commonwealth has reduced the number of individuals living on Group Homes of more than 4 beds by 841 (34%), (2,446 to 1605 individuals); while increasing the number of individuals living in group homes of 4 or fewer beds by 1,194 (55%), (2,189 to 3,383) individuals. Sponsored residential has increased by 521 (34%); (1,513 to 2,034) individuals; supported living by 171 (342%); (50 individuals to 221 individuals);

living with family by 2,434 ( 45%); (5,459 to 7,893) individuals; and living independently by 669 (313%); (214 to 883) individuals. (#5)

Also significant is the increased availability of integrated services statewide after the flat national and local experience of the pandemic. Table 1 recaps these changes between 2022 and 2023.

**Table 1**
**Integrated Settings per WaMS**

| | Spring 2022, Provider Data Summary | Spring 2023, Provider Data Summary |
|---|---|---|
| Person locality by integrated setting | 88% (13,527/15,428) | 90% (14,562/16,167) |
| Localities with 100% persons in integrated settings i.e., zero (0) persons in NON-integrated settings | 40 | 48 |
| Localities with 86%+ persons in integrated setting | 73% 99/135 | 94% 127/135 |
| Localities with 50% or fewer persons in integrated settings | 1 | 0 |

DBHDS established during the 22nd review period, a 47-member Developmental Disability Systems Issues and Resolution Workgroup (DDSIRW). This group was chartered to include stakeholders and to address issues that impact the development, expansion, and maintenance of developmental disability services, including integrated residential services. Workgroups are divided into 5 focused areas (Information Access, Workforce Growth, Community Options, Streamlining, System Transformation) plus a cross area Respite Workgroup. During the 23rd reporting period the DDSIRW continued to meet. DBHDS responded to a previous recommendation by the Expert Reviewer, Ric Zaharia and focused on respite barriers and challenges this reporting period. The required plan in these compliance indicators is achieved.

In its review of nursing services DBHDS provided the data analysis for six months of FY23 issuing the Nursing Services Data Report in June 2023. This report included data from FY23 Q1 and Q2. Unlike the previous year, DBHDS was not able to accelerate the review of data for FY23 Q3 and Q4. For the first six months of FY23 DBHDS reports that it has achieved the timeliness benchmark for the initial delivery of nursing to Waiver service recipients (42 individuals) but that it has not sustained this same accomplishment for EPSDT service recipients (12 individuals). Table 1 below depicts the achievements over the past three years. It also indicates DBHDS has not yet achieved the nursing utilization benchmark (i.e., receipt of the number of hours identified in the ISP 80% of the time) for 540 individuals. The previous Expert Reviewer indicated the impact of the 7.1.22 nursing rate increases might result in an achievement of this indicator, but it has not had that positive effect yet. It should be noted that utilization is the highest percentage it has been for both EPSDT and waiver recipients since

DBHDS began collecting and analyzing these data. DBHDS reviews all individuals whose nursing services were not initiated within thirty days of authorization. In only four situations was a staffing shortage noted as the reason for services not starting on time.

The Office of Integrated Health performed the review of the FY23 data for nursing services authorized and delivered from 7/1/22-12/31/22 of which some authorizations occurred in FY22. There were 540 unique individuals with 1,267 authorizations. Services were newly authorized for 54 unique individuals. The overall timeliness for the initiation of nursing services for those with new authorizations was for 42 (78%) of the 54 individuals. Utilization did not achieve the level of performance expected with only 246 (46%) of the 540 with service authorizations receiving 80% of the hours allotted. The Commonwealth explains that it has learned that the number of authorized hours for nursing services is often inflated to cover potential changes in need or unexpected events/emergencies and therefore is not an accurate replacement for "hours in the ISP". When providers of nursing services were surveyed after a training event, seven (29%) of the twenty-four providers reported requesting more hours than were potentially needed to cover unanticipated increases.

**Table 2**
**Nursing Services**

| | FY21 | FY22 | FY23 |
|---|---|---|---|
| EPSDT Timelines | 71% | 55% | 67% |
| Waiver Timeliness | 83% | 83% | 81% |
| EPSDT Utilization | 22% | 18% | 37% |
| Waiver Utilization | 30% | 36% | 47% |

*Note: the utilization percentages are based on the number of authorized hours which often varies from the number of hours identified in the ISP

The Commonwealth has expanded the provider stimulant Jump Start Funding to include nursing services. The Provider Data Summary published in May 2023 indicated DBHDS awarded $31,796.71 in funding during this reporting period. However, the nursing service utilization problem may be resistant to some improvement efforts. Virginia has yet to see significant impact from increasing the rates for nursing services but will hopefully see this in the next reporting period. However, the new rate established by DMAS remains below, at 90% of the market rate for nurses in Virginia in 2021. And finally, because of the episodic and difficult to predict nature of home healthcare (health need spikes, emergencies, etc.) and the presence of multiple service authorizations, the system has continued its tendency to over authorize nursing hours (#3). This suggests that the reported utilization rate will regularly fall below the actual utilization (i.e., needed number of hours vs. the delivered number of hours) by some measurable amount.

It is impressive that DBHDS completes a "Deep Dive" to ascertain the reasons for late starts for nursing services and to determine barriers to utilization. Two of the four children whose nursing services appeared to not start on time, did receive nursing services but they had not been billed either on time or accurately. One of the adults started thirty-one days after authorization. For the

remaining seven adults only four didn't start services because of a lack of nurses employed by the providers.

A further breakdown of the utilization data by living situation is provided. The percentage of individuals by living situation who receive at least 80% of the nursing hours allotted is as follows:

- Sponsored Home 18/29 62%
- Group Home 94/249 38%
- Living with Family 101/198 51%
- Living Independently 5/11 45%
- Supported Living 1/2 50%

DBHDS continues to refine nursing training and to convene stakeholders to identify unresolved barriers to the consistent and timely delivery of skilled and private duty nursing (PDN).

DBHDS also shared a draft of a proposed Intense Management Needs Review (IMNR) process which it has designed to assess and monitor the adequacy of management and supports provided to all individuals whose SIS evaluation results placed them in tier four level six (i.e. complex medical needs) to meet their needs. This process will also determine the extent to which nursing hours are delivered that are needed. DBHDS developed a monitoring questionnaire with the assistance of the Registered Nurse Care Consultants (RNCC) within the Office of integrated health OIH) in conjunction with the OIH Project Manager (#12). DBHDS plans to pull an annual statistically significant stratified statewide sample, reviewing 300 individuals' records each fiscal year. A RNCC will review the records, interview the Support Coordinator if necessary, and converse with the family/caregiver who will also complete the questionnaire. The RNCC will provide recommendations for improvements to documentation, offer technical assistance or training, and provide additional resources as a result of these reviews. The process will include quarterly reporting to various committees including the CMSC, annual reporting, and a look-behind process. This appears to be a promising practice; however, it is not possible to ascertain that without reviewing the questionnaire and reviewing the data produced by the first sample. I recommend the Independent Reviewer have a nurse consultant on his review team complete an in-depth review of this process in the next study period.

DBHDS noted in the previous reporting period an increase in families with children in nursing facilities who are requesting more information on community placement into more integrated settings. In this reporting period, compared to FY22 data there are two more children in NFs and 1 more child living in an ICF/IID. There are twenty-two fewer adults living in nursing homes. Adults living in ICF/IDDs continues to decrease with seventy-six fewer adults living in ICF/IDDs (other than training centers), and two fewer individuals in training centers. It is very positive that there are 174 more individuals living in independent housing. While not reflecting on any specific compliance indicator, this is a very positive step and is in the spirit of shifting the system toward integrated residential settings. Hopefully DBHDS will achieve this positive shift again for children by decreasing the number who live in either NFs or ICF/IDDs. (#2, 12).

In the 22nd review period, the Expert Reviewer made several recommendations. One was to seek input from consumers and family members to recommend ways to increase the readability and accessibility of the Community Transition Guide. DBHDS conducted a survey with members of

the System Issue Resolution Workgroup (SIRW) in July 2023 who suggested ways to address resource gaps but found the Guide to be user-friendly. The other recommendations focused on areas to be addressed by the Nursing Services Workgroup. DBHDS did address these recommendations. DBHDS staff completed an analysis of authorizations and updated training. DMAS will next conduct a similar analysis of the billing procedures. DBHDS analyzed a sample of 100 individuals who did not receive all their authorized hours and confirmed both the workforce challenges and that providers continue to request more hours than are needed to ensure the provider can address emergencies or increased level of need. (#9).

The Processes and Attestations for the CIs under review have all been verified in previous reporting periods. DBHDS submitted the list of changes that were made to these processes since the 22nd review period for the CMSC Data verification. None of these changes made any changes to measures or calculations that comprise the processes (#10,11)

**Compliance Indicator Achievement**

Table 3 below summarizes the status of the Compliance Indicators this study reviewed.

**Table 3**
**Community Living Options Findings**

| # | Indicator | Facts | Analysis and Conclusions | 22nd | 23rd |
|---|---|---|---|---|---|
| *18.2* | *a. Data continues to indicate an annual 2% increase in the overall DD waiver population receiving services in the most integrated settings* | Data showed a 2.3% increase in individuals receiving services in integrated settings between 3.31.22 and 3.31.23 (#2). Last year there was a 1.7% increase which improved the previous year's performance of 1.5%. | This indicator has consistently trended in a positive direction and is now achieved in the 23rd review period. | **NM** | **M** |
| *18.3* | *b. Data continues to indicate that at least 90% of individuals new to the waivers, including individuals with a "support needs level" of Levels 6 and 7, since FY 2016 are receiving services in the most integrated setting.* | The most recent available PDS (#2) showed 96% of all people new to the waiver FY16 to FY23-Q3 (including Levels 6 & 7) live in integrated settings. This analysis is based on the cumulative enrollee count since FY16. As of this reporting period, there are cumulatively 6,564 individuals new to the DD waivers of whom 6,292 are receiving services in the most integrated settings. | The data includes information about the individuals on the DD waivers whose support need is Level 6 or 7. As reported there are now cumulatively 1,003 individuals with a support need Level 6 or 7. Of these individuals, 959 (96%) are receiving services in the most integrated setting. This indicator is now achieved for two | **M** | **M** |

| | | | | | |
|---|---|---|---|---|---|
| | | | consecutive reporting periods. | | |
| *18.4* | *2. DBHDS continues to compile and distribute the Semi-annual Provider Data Summary …. The Data Summary indicates an increase in services available by locality over time.* | When the most recent Provider Data Summary (#3) for FY23 was analyzed by city/county individuals live in integrated residential services in 90% of Virginia localities as of Spring 2023, a 2% improvement over Spring 2022. Moreover, 48 of 135 cities/counties have no one living in non-integrated settings, compared to 40 in Spring 2022. There is no city/county where less than 82% individuals live in non-integrated settings. 94% of cities/counties have 86% or more individuals living in integrated settings, a 21% improvement over Spring 2021. (#7) | There is evidence that availability by locality over time is improving, due to more integrated services being offered and available in more locations. Therefore, this indicator has been achieved for the second consecutive period. | **M** | **M** |
| *18.5* | *3. DBHDS will establish a focus group with family members, individuals, and providers to identify potential barriers limiting the growth of sponsored residential, supported living, shared living, in-home supports, and respite for individuals with a "support needs level" of Level 6 or 7.* | DBHDS established a focus group on these barriers in 2019 (see #61). However, the role of family members, individuals, and providers in that focus group was unclear. The 2019 work of the Barriers Focus Group included recommendations for a potential workplan (see #61).<br><br>DBHDS has now convened a larger ongoing Issues Resolution Workgroup (DDSIRW (#4), which includes a cross-section of Self-Advocates and Family members, and which has continued and expanded on the 2019 work of the Barriers Focus Group.<br>During this reporting period discussions occurred with members of the workgroup. March 20-24, 2023, to | DBHDS established and convened the focus group in 2019 and documented the potential barriers the group identified. The roles of the group's members were not documented.<br><br>DBHDS has undertaken the challenge of addressing the barriers, identified in part by the focus group. In this period the focus on respite identified options for individuals living independently; options for those transitioning from school age to adult status; lack of respite for individuals on the waiver waitlist; lack of providers; time limitations; and low | **M** | **M** |

| | | | | | |
|---|---|---|---|---|---|
| | | identify barriers families experience receiving respite services. The members also discussed the challenges that providers face delivering respite services. Barriers and solutions were discussed and reported. | rates. DBHDS is analyzing the recommendations to address the identified challenges. The DDSIRW with broad stakeholder representation will continue to meet.<br><br>This indicator is now Met for two consecutive periods. | | |
| *18.6* | *DBHDS will report on how many individuals who are medically and behaviorally complex (i.e., those with a "support needs level" of Level 6 or 7) are using the following DD Waiver services, by category: sponsored residential, supported living residential, shared living, in-home supports, and respite services. Using this data and the focus groups, DBHDS will prepare a plan to prioritize and address barriers within the scope of its authority and establish timelines for completion with demonstrated actions.* | DBHDS reported on the numbers of individuals with Level 6-7 needs receiving services in the five areas (see #29):<br><br>Type L-6 L-7<br>SR 294 306<br>SLR 0 8<br>ShL 0 0<br>InHS 90 81<br>Resp 476 297<br><br>DBHDS provided a DDSIRW summary of the series of meetings referenced under 18.5 and the DBHDS summary and plan to address these barriers (#8). The budget considerations include: increase funding for transportation services to access respite; create a scholarship for non-waiver participants to access respite; increase the respite rate; and use Jump Start funding to incentivize provider development. DBHDS has developed a plan to address these issues and includes work with licensing; potentially change respite service requirements; make rate recommendations; and explore funding options for non-waiver participants and | The previous Expert Reviewer found this Not Met, but indicated once DBHDS developed a Plan that includes actions and a timetable this CI would be achieved. The Plan DBHDS submitted during this reporting period is sufficient to address the barriers to accessing respite services and building capacity. This CI is now met. | **NM** | **M** |

| | | | | | |
|---|---|---|---|---|---|
| | | to increase provider capacity. (#8) | | | |
| *18.9* | *6. DBHDS established a baseline annual utilization rate for private duty (65%) and skilled nursing services (62%) in the DD Waivers as of June 30, 2018, for FY 2018. The utilization rate is defined by whether the hours for the service are identified a need in an individual 's ISP and then whether the hours are delivered. Data will be tracked separately for EPSDT and waiver funded nursing. Seventy percent of individuals who have these services identified in their ISP (or, for children under 21 years old, have prescribed nursing because of EPSDT) must have these services delivered within 30 days, and at the number of hours identified in their ISP, eighty percent of the time.* | DBHDS issued its Nursing Services Data Report: Six Month Review of FY23 (#3) or this reporting period there was a total of 540 unique individuals and an additional 54 unique individuals with ID/D with a new service authorization that began in FY23.<br><br>**Timeliness**: Of these 54 individuals, 42 (78%) started services within 30 days. These numbers include 12 children receiving EPSDT and 42 adults receiving waiver services. Eight (67%) of the 12 children; and 34 (81%) of the 42 adults with waiver services received nursing services within 30 days.<br><br>**Utilization:** 540 individuals utilized EPSDT or waiver nursing services. Only 246 (46%) received 80% of the hours that were allotted to them. This includes 29 (37%) of the 79 children receiving nursing through EPSDT, and 217 (47%) of the 461 adults receiving DD waiver services.<br><br>The Commonwealth should increase its reimbursement rates for nursing services to ensure that there are a sufficient number of nurses to provide at least 80% of continuing nursing services for those individuals with intense healthcare support needs. The increased rates should be sufficient to | This indicator has not yet been fully achieved. It will be achieved when both the timeliness and utilization metrics are reached.<br><br>The indicator requires that the percentage of hours delivered be determined. The Commonwealth reports that the Parties believed when this Indicator was agreed upon that the number of hours of needed nursing hours was specified in the ISP. However, DBHDS later confirmed that this was not the case and instead uses the number of authorized hours to indicate the number of hours needed. However, since using this alternative method, the Commonwealth learned that, as explained above this may not always be an accurate portrayal and may inflate the number of needed nursing hours (to address emergencies and unpredictable increases in need).<br><br>When the data are compared to timeliness and utilization in FY22 the following differences emerge. The timeliness of starting services for children using EPSDT improved from 54.5% | **NM** | **NM** |

| | | | | | |
|---|---|---|---|---|---|
| | | provide nurses with employment benefits and travel reimbursement that are competitive with the current market rates in Virginia for serving individuals in, at times, challenging environments.<br><br>DBHDS acknowledges that the requested hours are often inflated to ensure approval for both RN and LPN levels of nursing as the team may not know which level of nursing will be available. The request for nursing hours also often includes additional hours to ensure future health emergencies can be responded to timely.<br><br>DBHDS should develop criteria and a protocol that allows them to report and analyze the accurate hours of nursing services needed compared to utilization for the purposes of responding to this CI. | to 67% beginning to receive services within 30 days. However, it decreased from 83% to 81% for adults on the I/DD waivers. The Commonwealth still exceeded this indicator 70% performance benchmark, so this requirement of timeliness is achieved again.<br>The Commonwealth has also committed to 70% of individuals needing nursing services receiving the number of hours in their ISP 80% of the time. The Commonwealth has not achieved this requirement, only 46% of the 540 individuals with authorized nursing services received the hours allotted to them 80% of the time.<br><br>DBHDS began collecting utilization data in FY 21, which was the height of the pandemic and like many other services a lower point for nursing services utilization than in 2018. Since that low point of approximately 30% utilization, the percentages have steadily increased for adults. Since FY21, 17% more adults receive 80% of the allotted nursing hours to meet their needs. The percentage increased from 30% in FY21, to 36% in FY22 and to 47% in FY23, but only for half the | | |

| | | | | | |
|---|---|---|---|---|---|
| | | | year.<br>(#3). There has also been an increase in the percentage for children since FY21 after a decrease in FY22 in terms of the utilization of nursing hours. This percentage was 22% in FY21, 18% in FY22 and is now 37% through FY23 Q2.<br><br>DBHDS reported that the methodology that it used to establish this indicator's baseline for the utilization of nursing services cannot be replicated. Therefore, this reviewer was not able to determine whether the actual utilization rate for FY 23 was higher or lower than the actual baseline if the same calculation methodology was utilized. Regardless of its relationship to the baseline, this CI has not been achieved as it cannot be determined that 70% of individuals are receiving 80% of the nursing hours they need | | |

Recommendation: DBHDS should develop and implement a new approach to establish a utilization rate that accurately determines the extent to which individuals with a need identified in their ISPs have the needed number of nursing hours delivered.

Attachment A
Documents Reviewed
Title or Filename

1. CLO 23rd Study Period Document Tracker
2. Provider Data Summary FY23: Issued May 2023
3. DBHDS Nursing Services Data Report June 2023
4. DDSIRW Workgroup Report (not dated)
5. HCBS Residential Settings Report 4.15.23
6. Integrated Employment and Day Services Report
7. HCBS Residential Settings Report by Locality 5.5.23
8. DBHDS Plan to Improve Access to Waiver Services
9. Consultant Reponses 10.11.23
10. Provider Data Summary Process VER_011
11. DD_CMSC_VER_018
12. Intense Management Needs Review

Submitted by:
Kathryn du Pree MPS
Expert Reviewer
November 1, 2023

# APPENDIX G

## Services for Individuals
## with
## Complex Medical Support Needs

**by**

**Elizabeth Jones, MS, Team Leader**
**Marisa C. Brown, MSN, RN**
**Barbara Pilarcik, RN**
**Julene Hollenbach, RN, BSN, NE-BC**
**Michael West, Ph.D.**

# TWENTY-THIRD PERIOD INDIVIDUAL SERVICES REVIEW STUDY:

## Individuals with Complex Medical Needs

Submitted By:

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November 5, 2023

## Introduction/Overview

The Independent Reviewer's diligent attention to individuals with complex medical needs is reflected once again in the work completed for the twenty-third review period's Individual Services Review (ISR) Study. As in prior review periods, a team of highly experienced nurses conducted an in-depth assessment of the health care provided to children, adolescents, and adults with a developmental disability and a heightened risk due to a level 6 score on their Supports Intensity Scale (SIS) evaluation.

Although a substantial amount of information was gathered about each person in the Study, the focus of this narrative concentrates on two specific Compliance Indicators that are critical to ensuring health and safety in community-based residential settings under the Commonwealth's jurisdiction:

III.D.1. Compliance Indicator 18.9: Seventy percent of individuals who have these (nursing) services identified in their ISP…must have these services delivered within 30 days, and at the number of hours identified in their ISP, eighty percent of the time.

V.B Compliance Indicator 29.20: At least 86% of the people supported in residential settings will receive an annual physical exam, including review of preventive screenings, and at least 86% of individuals who have coverage for dental services will receive an annual dental exam.

As the Commonwealth continues to work to strengthen its community-based system of care by providing individualized health-related supports to people with complex medical needs, the findings from this Study may be especially notable. First, 15 of the people in the sample (62.5%) live in their family home. As a result, the caregiving responsibilities are managed primarily by parents and/or siblings. Parents and siblings who work outside the home frequently described how they must juggle their job responsibilities with the caregiving responsibilities for their family members with a developmental disability, especially when the assigned nursing services are unreliable. The lack of consistent in-home nursing support threatens the stability of being able to live with one's family, thereby creating the possible necessity of transfer to a group home, sponsored home, or nursing facility. In this regard, the stress experienced by elderly parents is of particular concern. Second, despite the complexity of the medical conditions experienced by individuals in the sample, which includes those who use ventilators, have tracheostomies, or are confined to bed, it is clear that they can be supported in an integrated community-based residence. However, the nature of their medical conditions underscores the need to support them and their caregivers, on an ongoing and continuous basis, with skilled and experienced health care staff who are capable of working in a home environment, possibly one with limited space and inadequate accessibility. Third, when there are delays in obtaining adaptive equipment or environmental modifications, there are additional burdens on both the individual and the caregiver.

In order to demonstrate compliance, it remains essential that the Commonwealth continue to assess the systemic barriers that interfere with nurses being available to support individuals with complex medical needs and then implement timely and comprehensive remedial actions, as indicated, at the regional level and in individual cases.

## Methodology

In early August 2023, the Independent Reviewer selected a sample of 24 individuals from the cohort of 36 individuals whose SIS evaluation results placed them in level 6 (intense medical needs); whose annual ISP meeting was held in either August or September 2022; and whose need for nursing services was identified in their ISP. This sample provides 90% confidence that the findings from this Study can be generalized to the cohort as a whole.

Once the sample was selected, with very timely and thorough assistance from DBHDS, on-site visits were scheduled with all primary residential contacts. Visits to each residence were conducted by one of the three nurse consultants from August 28 to September 14, 2023. Documentation, including the ISP, the Health Care Plan, and the authorization form (CMS 485) for nursing services, was provided in advance for each person. Supplemental documentation, such as medical consults and medication administration records, were examined during the ISR nurses' site visits. Following the interview(s), the information for each person was recorded on the updated ISR Monitoring Questionnaire, revised by the Independent Reviewer and DBHDS leadership staff in order to include facts about the use of nursing services. The Issues Page of the Monitoring Questionnaire was completed, if necessary, to highlight a health-related matter of concern to be remedied by DBHDS and reported back to the Independent Reviewer by March 31, 2024. Copies of each Monitoring Questionnaire will be provided to the Parties. Additionally, responses to the Monitoring Questionnaires were aggregated for analysis of the overall findings. Tables summarizing the findings are included in Attachment A.

## Characteristics of the Sample

The cohort for the ISR study was all 36 individuals with SIS level 6 needs (i.e., complex medical) who had ISP meetings in August or September 2022. All DBHDS Regions are represented in the randomly selected sample of 24 individuals. Region II has 11 individuals (45.8%); Regions IV and V have 4 individuals each (16.7%); Region I has 3 individuals (12.5%); and Region III has 2 individuals (8.3%).

Fourteen males and ten females are included in the sample. The largest age group (29.2%) is comprised of children and adolescents 21 years old or younger. The next largest age groups are between ages 21 to 30 (25%) and ages 31 to 40 (20.8%). The oldest person in the sample is 76 years old.

None of the individuals are ambulatory. Twenty individuals (83.3%) use a wheelchair; three people (12.5%) are confined to bed; one person (4.2%) walks with support.

As noted above, most of the individuals in the sample (66.7%) live in their own/family home. (One of the family homes is also a sponsored home.) Group homes support eight individuals (33.3%).

A Demographic Table is included in Attachment A.

## Discussion of Major Findings

Although the intensity and frequency of the specific medical conditions vary among the individuals in the sample, they share many of the same diagnoses. For example, 96% of the individuals have choking precautions; 79% are being tube-fed; 63% require suctioning; 67% have bowel elimination problems; and 83% have a major seizure disorder. The discrete issues related to the health care needs of every person in the sample are described in the Monitoring Questionnaires completed after each site visit. Tables with the aggregated information are included in Attachment A.

The findings specifically related to the two Compliance Indicators at the center of this Study are summarized below.

III.D.1. Compliance Indicator 18.9:

In light of the complex and overlapping medical conditions experienced by the people in the sample, nursing services that are consistent, reliable, and skilled are critical for their health and safety. Since most of the people reviewed are living in family settings, the regular presence of a qualified nurse is both an important safeguard and a reassurance for the family caregivers.

Prior to initiating this Study, DBHDS provided information about the actions required to obtain authorized nursing service hours. Each of these requisite steps was examined as part of the Study's process. The findings indicate that: 1) 50% of the ISPs specified, in Part V, the number of nursing hours to be provided; 2) Although one CMS 485 form for one person could not be located, based on the other documentation available, it is determined that, after the assessment by a qualified health professional, the need for nursing services resulted in the completion of a Health Care Plan (CMS 485) and that the schedule of activities and/or Part 3 specified the number of nursing hours identified on the CMS 485. Based on this information, with the exception of documenting in the ISP itself, the process for determining the need for nursing service and the number of hours required and that should be authorized appears to be implemented consistently for the people included in this Study.

However, the most serious finding in this Study is the inconsistency and unreliability of nursing services for 19 people (79%). The impact of the lack of consistent nursing services, often on an unpredictable basis, was a concern to most of the caregivers and was described by one mother as a "nightmare."

Although DBHDS provided data regarding the number of nursing hours authorized and the number actually billed, it is difficult to compare the data across individuals because the reporting timeframes are not uniformly consistent. In addition, some of the nursing utilization percentages were averages reported over extended time periods that prevented identifying patterns of inconsistency. Also, information gathered during the site visit interviews raised questions about whether the data provided a valid portrayal of the situation. For example:

Data reported by DBHDS for Individual #22, who lives with his family, indicates that he had received 97.23% of his nursing hours from February 1, 2022 until July 31, 2022 and 80.26% from August 1, 2022 to January 31, 2023. DBHDS does not provide data for the time after

February 1, 2023 when the family states that the number of authorized nursing hours were not received and were frequently left unfilled by the agency. This gentleman has a tracheostomy and may use a ventilator.

DBHDS reported more than one billing period for the individuals in the sample. As noted above, the reporting timeframes are not uniform across individuals. Therefore, for the purpose of this analysis, the data from the last reported billing period for each person are referenced in the summary paragraphs below.

According to the data provided by DBHDS, there are five individuals (#s 06, 09, 13, 17, 19) in the sample (21%) who received all (or more than 100%) of their authorized nursing hours. Two of these individuals (#09, 17) live in group homes where the nursing coverage is shared across all people living in the house. Upon inquiry, the group home staff agreed that the nursing hours were provided as authorized because there is nursing coverage at all times.

The percentage of nursing hours provided to the other nineteen individuals in the sample (79%) ranges from zero (0.00%) for Individual # 18 to 97.4% for Individual #07. Two individuals (#s16, 24) received fewer than 20% of their authorized hours. Five individuals (#s 02, 03, 04, 08, 14) received less than 60% of their authorized hours. Six individuals (#s 05, 10, 11, 12, 15, 20) received between 60% and 80% of their authorized hours. Four individuals (#s 01, 21, 22, 23) received between 80% and 86% of their authorized hours. For the sample of 24 individuals who were randomly selected for this Study, only ten (42%) received 80% or more of the number of authorized nursing hours.

Given their complicated medical conditions, the lack of nursing services to the people in this sample has potentially serious, even grave, consequences, including avoidable/unnecessary out-of-home placement. The factors underlying this systemic deficiency are well recognized in the Commonwealth and in the nation as a whole. The inadequate compensation, coupled with the demands and responsibility of the in-home nursing work itself, are the reasons that were consistently cited throughout the interviews conducted for this Study.

V.8 Compliance Indicator 29.20:

Information about physical and dental exams was obtained through document review and interviews. There is evidence that 21 of the people in the sample (87.5%) had an annual physical exam. Three people (12.5%) did not have the requisite examination. In two instances, the reason for the failure to obtain this important assessment was stated as oversight by a parent and a group home provider. In the third instance, the parent did not provide an explanation. All lab work was completed as ordered by the physician. With one exception, all physician ordered diagnostic tests and medical specialists' recommendations were completed within the recommended timeframe. Furthermore, all monitoring ordered by the physicians was implemented, including the monitoring of seizures, fluid and food intake, tube feedings, weight fluctuations and positioning protocols.

One person (#13) is known to lack dental coverage. Dental exams were conducted annually for 15 people in the adjusted sample (65%). Recurring difficulties with obtaining dental care persisted for eight people in the adjusted sample (35%). The obstacles experienced by these

people have been identified repeatedly in past ISR Studies. The problems include dentists who do not provide sedation; dentists uncomfortable with positioning; dentists uncomfortable with treating medically challenged people; long travel distances to reach a qualified dentist; and individual or family resistance to dental appointments. One group home provider experienced difficulty in reaching the Department's mobile dental unit in order to schedule a future appointment.

Using the information described above, the following chart summarizes the results of the Study on an individual-by-individual basis. The details underlying these determinations are included in the Monitoring Questionnaires provided to the Parties.

**Summary of Individual Findings**

| ID# | Family home or Group home | Annual Physical Exam | Annual Dental Exam | 80% of authorized nursing hours were received |
|---|---|---|---|---|
| 01 | Family | Yes | No | Yes |
| 02 | Family | Yes | Yes | No |
| 03 | Group | No | Yes | No |
| 04 | Family | Yes | No | No |
| 05 | Group | Yes | No | No |
| 06 | Family | Yes | Yes | Yes |
| 07 | Group | Yes | Yes | Yes |
| 08 | Family | Yes | No | No |
| 09 | Group | Yes | Yes | Yes |
| 10 | Family | Yes | No | No |
| 11 | Family | Yes | Yes | No |
| 12 | Family | Yes | Yes | No |
| 13 | Family | No | No but lacks coverage | Yes |
| 14 | Family | Yes | Yes | No |
| 15 | Group | Yes | No | No |
| 16 | Family | Yes | Yes | No |
| 17 | Group | Yes | Yes | Yes |
| 18 | Group | Yes | Yes | No |
| 19 | Family | Yes | Yes | Yes |
| 20 | Family | Yes | Yes | No |
| 21 | Family | No | No | Yes |
| 22 | Family | Yes | No | Yes |
| 23 | Group | Yes | Yes | Yes |
| 24 | Family | Yes | Yes | No |
| **% Received** | | **87.5%** | **65%** | **42%** |

## Concluding Comments

The work conducted in this twenty-third review period documents the current health care status of 24 individuals with a developmental disability who are entitled to receive services from the Commonwealth under the terms of the Settlement Agreement. The Study benefitted greatly from the timely and collaborative assistance given by the Assistant Commissioner, Developmental Services, and her staff; this cooperation is very much appreciated. The interviews with families and group home staff were cordial and productive. Caregivers and, where possible, the individuals themselves were both generous with their time and thoughtful in their responses. They welcomed the nurses into their homes. It was a pleasure to meet them.

Although there are positive findings regarding the completion of annual physical examinations and the follow-up conducted as a result of those consultations by physicians and medical specialists, the Commonwealth did not meet both 86% requirements of Compliance Indicator 29.20. The ongoing deficiencies in the provision of dental care for 35% of the individuals in this sample necessitates a recommended finding of Not Met for this obligation. Although the problems in accessing timely dental care have been well documented over many years, the gaps in the availability of qualified dentists with the knowledge, skills, and capacity to treat children and adults with a developmental disability remain unresolved. Dental care is essential for health, especially for people who are vulnerable due to complex medical conditions.

This Study's examination of the provision of authorized nursing services presents serious and persistent questions about the adequacy of the resources expected for individuals, of all ages, who are medically complex and dependent on the Commonwealth for the protection of their health and safety. The stress on the families who are the primary caregivers is of notable concern. There is evidence from the site visits that certain living situations are at potential risk, including of avoidable or unnecessary out-of-home placement, due to the lack of reliable in-home support from nursing personnel. As a result of this Study's intensive review of the 24 people in the sample, the Commonwealth provided less than 80% of needed nursing hours to 14 of the 24 individuals (58%) in the sample and only provided 10 individuals (42%) with 80% or more of the needed number of hours of nursing services. Therefore, for the cohort of 36 individuals in this Study, the Commonwealth did not meet the Compliance Indicator 18.9 requirement that 70% of individuals with a need identified in their ISPs received at least 80% of the hours needed.

**ATTACHMENT A**

# Demographic Tables

| Region | | |
|---|---|---|
| I | 3 | 12.5% |
| II | 11 | 45.8% |
| III | 2 | 8.3% |
| IV | 4 | 16.7% |
| V | 4 | 16.7% |

| Sex | | |
|---|---|---|
| Male | 14 | 68.3% |
| Female | 10 | 41.7% |

| Age Group | | |
|---|---|---|
| Under 21 | 7 | 29.2% |
| 21-30 | 6 | 25.0% |
| 31-40 | 5 | 20.8% |
| 41-50 | 2 | 8.3% |
| 51-60 | 1 | 4.2% |
| 61-70 | 2 | 8.3% |
| 71-80 | 1 | 4.2% |
| 81-90 | 0 | 0.0% |
| Over 90 | 0 | 0.0% |

| Mobility Status | | |
|---|---|---|
| Walks without support | 0 | 0.0% |
| Walks with support | 1 | 12.5% |
| Uses wheelchair | 20 | 83.3% |
| Confined to bed | 3 | 0.0% |

| Residence Type | | |
|---|---|---|
| Group home | 8 | 33.3% |
| Own/family home | 15 | 62.5% |
| Sponsored home | 1 | 4.2% |

*INDIVIDUAL'S SUPPORT PLAN/PLAN OF CARE*

| *Item No.* | *Item* | *n* | *Y* | *N* | *CND* | *Y%* | *N%* | *CND%* |
|---|---|---|---|---|---|---|---|---|
| *34* | Is the Individual's Support Plan current? | 24 | 24 | 0 | 0 | 100% | 0% | 0% |
| *35* | Has the Individual's Support Plan been modified as necessary in response to a major health-related event for the person, if one has occurred? | 2 | 2 | 0 | 0 | 100% | 0% | 0% |
| *39* | Does the Individual's Support Plan have specific and measurable outcomes and support activities? | 24 | 1 | 23 | 0 | 4% | 96% | 0% |
| *45* | Does the individual require adaptive equipment? | 24 | 24 | 0 | 0 | 100% | 0% | 0% |
| | a. If Yes, is the equipment reported as available? | 24 | 22 | 2 | 0 | 92% | 8% | 0% |
| | b. If No, has it reportedly been ordered? | 2 | 2 | 0 | 0 | 100% | 0% | 0% |
| | c. If available, is the equipment reportedly in good repair and functioning properly? | 24 | 19 | 5 | 0 | 83% | 17% | 0% |
| | d. If No, has the equipment reportedly been in need of repair more than 30 days? | 5 | 4 | 1 | 0 | 80% | 20% | 0% |
| | e. If No, has anyone reportedly acted upon the need for repair? | 5 | 3 | 2 | 0 | 60% | 40% | 0% |
| *48* | Is the individual receiving supports identified in his/her Individual Support Plan? | | | | | | | |
| | a. Residential/In-Home | 24 | 24 | 0 | 0 | 100% | 0% | 0% |
| | b. Medical (physician and medical specialists) | 24 | 24 | 0 | 0 | 100% | 0% | 0% |
| | c. Dental | 24 | 15 | 9 | 0 | 63% | 38% | 0% |
| | d. Health (nursing and other health supports) | 24 | 19 | 5 | 9 | 79% | 21% | 0% |
| | d(1). Did the ISP specify the number of nursing hours to be provided? | 24 | 12 | 12 | 0 | 50% | 50% | 0% |
| | d(2) If so, after the assessment by a qualified health professional, did the need for nursing services result in the completion of a Health Care Plan (CMS 485)? | 24 | 23 | 1 | 0 | 96% | 4% | 0% |
| | d(3). If so, did the schedule of activities and/or Part 3 specify the # of nursing hours identified on the CMS 485 to be | 24 | 12 | 12 | 0 | 50% | 50% | 0% |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | provided? | | | | | | | |
| | g. Mental Health | 4 | 3 | 1 | 0 | 75% | 25% | 0% |
| | g(1) Mental Health: Psychiatry | 3 | 2 | 1 | 0 | 67% | 33% | 0% |
| | i. Communication/assistive technology, if needed | 0 | | | | | | |

*EALTH CARE SURVEY*

| *Item No.* | *Item* | *n* | *Y* | *N* | *CND* | *Y%* | *N%* | *CND%* |
|---|---|---|---|---|---|---|---|---|
| *97* | If ordered by a physician, was there a current physical therapy assessment? | 9 | 8 | 1 | 0 | 89% | 11% | 0% |
| *98* | If ordered by a physician, was there a current occupational therapy assessment? | 4 | 4 | 0 | 0 | 100% | 0% | 0% |
| *99* | If ordered by a physician, was there a current psychological assessment? | 3 | 3 | 0 | 0 | 100% | 0% | 0% |
| *100* | If ordered by a physician, was there a current speech and language assessment? | 2 | 2 | 0 | 0 | 100% | 0% | 0% |
| *101* | If ordered by a physician, was there a current nutritional assessment? | 12 | 12 | 0 | 0 | 100% | 0% | 0% |
| *102* | Were any other relevant medical/clinical evaluations or assessments recommended? | 18 | 13 | 5 | 0 | 72% | 28% | 0% |
| *103* | Are there needed assessments that were not recommended? | 18 | 6 | 12 | 0 | 33% | 67% | 0% |
| *104* | Are clinical therapy recommendations (OT, PT, S/L, psychology, nutrition) implemented or is staff actively engaged in scheduling appointments? | | | | | | | |
| | a. OT | 5 | 5 | 0 | 0 | 100% | 0% | 0% |
| | b. PT | 14 | 14 | 0 | 0 | 100% | 0% | 0% |
| | c. S/L | 1 | 0 | 1 | 0 | 0% | 100% | 0% |
| | d. Psychology | 2 | 2 | 0 | 0 | 100% | 0% | 0% |
| | e. Nutrition | 13 | 13 | 0 | 0 | 100% | 0% | 0% |
| | f. Other | 1 | 1 | 0 | 0 | 100% | 0% | 0% |
| *105* | Did the individual have a physical examination within the last 12 months or is there a variance approved by the physician? | 24 | 21 | 3 | 0 | 88% | 12% | 0% |
| *106* | Did the individual have a dental examination within the last 12 months or is there a variance approved by the | 24 | 15 | 9 | 0 | 63% | 38% | 0% |

*EALTH CARE SURVEY*

| *Item No.* | *Item* | *n* | *Y* | *N* | *CND* | *Y%* | *N%* | *CND%* |
|---|---|---|---|---|---|---|---|---|
| | dentist? | | | | | | | |
| *107* | Were the dentist's recommendations implemented within the time frame recommended by the dentist? | 20 | 13 | 7 | 0 | 65% | 35% | 0% |
| *108* | Were the Primary Care Physician's (PCP's) recommendations addressed/implemented within the time frame recommended by the PCP? | 24 | 23 | 1 | 0 | 96% | 4% | 0% |
| *109* | Were the medical specialist's recommendations addressed/implemented within the time frame recommended by the medical specialist? | 24 | 23 | 1 | 0 | 96% | 4% | 0% |
| *110* | Is lab work completed as ordered by the physician? | 23 | 23 | 0 | 0 | 100% | 0% | 0% |
| *112* | Are physician ordered diagnostic consults completed as ordered within the time frame recommended by the physician? | 19 | 18 | 1 | 0 | 95% | 5% | 0% |
| *114* | Is there monitoring of fluid intake, if applicable per the physician's orders? | 11 | 11 | 0 | 0 | 100% | 0% | 0% |
| *115* | Is there monitoring of food intake, if applicable per the physician's orders? | 2 | 2 | 0 | 0 | 100% | 0% | 0% |
| *116* | Is there monitoring of tube feedings, if applicable per the physician's orders? | 14 | 14 | 0 | 0 | 100% | 0% | 0% |
| *117* | Is there monitoring of seizures, if applicable per the physician's orders? | 20 | 20 | 0 | 0 | 100% | 0% | 0% |
| *118* | Is there monitoring of weight fluctuations, if applicable per the physician's orders? | 17 | 17 | 0 | 0 | 100% | 0% | 0% |
| *119* | Is there monitoring of positioning protocols, if applicable per the physician's orders? | 11 | 11 | 0 | 0 | 100% | 0% | 0% |
| *130* | Does this individual receive psychotropic medication? | 24 | 10 | 14 | 0 | 42% | 58% | 0% |
| *133* | If Yes, is there documentation that the individual and/or a legal guardian has given informed consent for the use of psychotropic medication(s)? | 10 | 6 | 4 | 0 | 60% | 40% | 0% |
| *134* | Does the individual's nurse or psychiatrist conduct monitoring as indicated for the potential development of tardive dyskinesia, or other side effects of psychotropic | 7 | 1 | 1 | 5 | 14% | 14% | 71% |

*EALTH CARE SURVEY*

| *Item No.* | *Item* | *n* | *Y* | *N* | *CND* | *Y%* | *N%* | *CND%* |
|---|---|---|---|---|---|---|---|---|
| | medications, using a standardized tool (e.g., AIMS) at baseline and at least every 6 months thereafter)? | | | | | | | |
| *135* | Do the individual's clinical professionals conduct monitoring for digestive disorders that are often side effects of psychotropic medication(s), e.g., constipation, GERD, hydration issues, etc.? | 7 | 5 | 0 | 2 | 71% | 0% | 29% |
| *136* | Is there any evidence of administering excessive or unnecessary medication(s), including psychotropic medications? | 24 | 1 | 22 | 1 | 4% | 92% | 4% |

*SUMMARY AND SUPPLEMENTAL QUESTIONS*

| *Item No.* | *Item* | *n* | *Y* | *N* | *CND* | *Y%* | *N%* | *CND%* |
|---|---|---|---|---|---|---|---|---|
| *137* | Based on documentation reviewed and interview (s) conducted, is there any evidence of actual or potential harm, including neglect? | 24 | 3 | 21 | 0 | 13% | 88% | 0% |
| | a. Was a Risk Assessment Tool completed for the annual ISP meeting? | 3 | 3 | 0 | 0 | 100% | 0% | 0% |
| | b. Did it cite any evidence of actual or potential harm, including neglect? | 3 | 0 | 3 | 0 | 0% | 100% | 0% |
| *138* | In your professional judgment, does this individual's health care require further review? | 24 | 5 | 19 | 0 | 21% | 79% | 0% |
| *141* | Has there been a psychiatric hospitalization? | 24 | 0 | 24 | 0 | 0% | 100% | 0% |
| *142* | Have there been any events related to the individual's high risk health factors (i.e., aspiration, choking, constipation, falls, etc.) | 24 | 6 | 18 | 0 | 25% | 75% | 0% |
| | b. If Yes, are those who support the individual aware of any DBHDS alert about the risk factor(s)? | 4 | 0 | 4 | 0 | 0% | 100% | 0% |
| | c. If Yes, have any protocols or procedures been created or modified as a result? | 1 | 0 | 1 | 0 | 0% | 100% | 0% |
| *143* | Has there been an emergency room visit or unexpected medical hospitalization? | 24 | 18 | 6 | 0 | 75% | 25% | 0% |
| *147* | Has there been the use of physical, chemical, or mechanical restraint? | 24 | 0 | 24 | 0 | 0% | 100% | 0% |
| *152* | a. Did the Case Manager identify an unidentified or inadequately addressed health-related risk, injury, need, or change in status? | 10 | 1 | 9 | 0 | 10% | 90% | 0% |
| | b. If Yes or No, did they document, report, and convene the ISP team? | 10 | 1 | 9 | 0 | 10% | 90% | 0% |

# APPENDIX H

## Mortality Reviews

**by**

**Wayne Zwick, MD**

**Re: Review of the Mortality Review requirements in the Settlement Agreement, U.S. vs. Commonwealth of Virginia**
**22nd and 23rd Review periods**
**November 6, 2023**
By Wayne Zwick M.D.

**Background**

The 21st period review (August 2021 through July 2022) found that the MRC (Mortality Review Committee) continued to make advances toward fulfilling the requirement of the fifteen compliance indicators and thirty-one sub indicators for V.C.5. The 21st period's study of the DBHDS Mortality Review Committee's reviews of deaths included validation of the reliability and validity of the MRC reviewed data confirmed by DBHDS and found to be consistent with the findings during the study review. The study verified that the MRC continued to have access to medical records from several sources, which included assistance of the Specialized Investigations Unit - Office of Licensing. Based on more complete medical information, more accurate causes of death, demographic information, and other parameters resulted in the Mortality Review Committee's continued ability to track reliable quality data. This led to the improved identification of potentially preventable deaths. The MRC continued to track the implementation of action steps it recommended and continued to follow them to closure. The review found that DBHDS had an effective system in place to minimize unreported deaths. With more complete medical information, the number of cases with an unknown cause of death was reduced, and there was increased accuracy in categorizing deaths as potentially preventable or not potentially preventable. The MRC incorporated the Curative action definitions into its processes beginning January 2022.

The 21st period study found that the Commonwealth had not met the requirement of Indicator 33.13 (i.e. 86% of unexplained/unexpected deaths reported through DBHDS incident report system have a completed MRC review within 90 days of death) or the related indicator 33.15 (i.e. MRC report delivered to the DBHDS Commissioner of deliberations, findings, and recommendations for 86% of deaths requiring review within 90 days of death). Historically, these two indicators were determined conditionally Met* during the 17th review period and were found not to have been achieved, i.e. performance had declined, during the 19th and 21st period reviews. The Commonwealth anticipated that this area of compliance would be resolved and the 21st period's review would be able to make this determination following the gathering and analyzing of ample evidence from the requested documentation. However, DBHDS was not able to be achieve this performance metric at the time of the 21st period's review, although there was progress in achieving completed MRC review within 90-days of death (compliance rate of 52% for review of unexpected death within 90 days),.

The 21st Period review found that the Commonwealth had met the requirements of the other nineteen Mortality Review compliance indicators (CIs 33.1-33.12, 33.14, and 33.16-33.21) and verified that the data reported were reliable and valid.

**22nd and 23rd Review Period Summary**

The 22nd and 23rd period reviews focused on the MRC's progress achieving 'Met' status for compliance indicators 33.13 and 33.15, as well as mortality data reliability testing during the time period of the 23rd review.

Compliance Indicator 33.13

> *"86% or greater of unexplained or unexpected ID/DD deaths as reported through the DBHDS incident reporting system have a complete review by the MRC within 90 days of the date of the death."*

For the 22nd review period, this review determined that 94% of the MRC's completed reviews of unexpected deaths per calendar month from November 2022 through March 2023 occurred within 90 days. As detailed in Attachment 2, this percentage calculation excluded October during which the MRC completed the reviews of six older deaths to catch up on the reviews of all deaths. It is this reviewer's opinion that the MRC achieved the intended 86% performance measure requirement of compliance indicator 33.13 for the 22nd Period.

For the 23rd review period, the MRC completed 86% of its review for unexpected deaths within 90 days, As detailed in Attachment 3 . This review verified that the MRC 'Met' the performance measure requirements for compliance indicator 33.13.

Compliance Indicator 33.15

> *"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. If the MRC elects not to make any recommendations, it must affirmatively state that no recommendations were warranted."*

For three consecutive quarters, the MRC completed and submitted Quarterly Report to the Commissioner Q3 FY23 that included the required information: its deliberations, findings and recommendations. In addition, these reports stated affirmatively when the MRC made no recommendations. During these quarters these reports detailed the MRC findings for 88% of unexpected deaths. For each of the first two of these quarters (FY 23 Q2 and FY 23 Q3), the MRC reviewed 94% of the unexpected deaths within 90 days. For the third quarter (FY 23 Q4), there were very few unexpected deaths and the MRC completed reviews of 6 older cases, which reduced the rate reviewed to 77%. It is the opinion of this reviewer that the MRC fulfilled the purpose of indicator 33.15 by submitting three consecutive quarterly reports with the required information that cumulatively include 88% of the unexpected deaths. (see Attachment 4)

**Methodology**

The findings and conclusions of this review are based on the documents provided. The following documents were submitted for review during this time period:

**22nd Review Period:** DBHDS MRC meeting minutes, DBHDS MRC Notes Summary, and electronic Mortality Review Forms (eMRF) for 10/13/22, 10/27/22, 11/30/22, 12/15.22, 01/12/23, 01/26/23, 02/09/23, 02/23/23, 03/09/23, and 03/23/23.

22nd Review Period: MRC Quarterly Reports to Commissioner Q2 and Q3 FY23

22nd Review Period: MRC Action Tracking Log 10/13/22-03/23/23

22nd Review Period: Data Set Attestation Form for data sets and visualization validation form MDPS (October – Dec 2022) with signature of Chief Information Officer, and effective date 4/1/23.

**23rd Review Period:** DBHDS MRC meeting minutes, DBHDS MRC Notes Summary, and electronic Mortality Review Forms (eMRF) for: 04/13/23, 04/27/23, 05/11/23, 05/25/23, 06/08/23, 06/22/23, 07/13/23, 07/27/23, DBHDS MRC meeting minutes and DBHDS MRC Notes Summary for: 8/10/23, 8/24/23, 9/14/23, and 9/28/23

23rd Review Period: MRC Action Tracking Lg FY 23 04/13/23-07/27/23

23rd Review Period: MRC Quarterly Report to Commissioner Q4 FY23

Data Set Attestation Form for data sets and visualization validation for MRC Death Data from 2.2023 - 7.31.2023. with signature of Chief Information Officer 10/17/23.

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**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.

The following Curative Steps were also agreed upon:
"• The Commonwealth shall revise its definition of potentially preventable deaths and the criteria it utilizes to determine which deaths are potentially preventable as needed …
• 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."

Compliance Indicators

The following compliance indicator table has been developed to track DOJ requirements of the MRC structure and process. Several indicators have been subdivided, as they often had several components. Evidence was then used to determine compliance with each subpart. Evidence was based on submitted documentation as well as with interviews with selected staff. The following indicators were found to have MET or NOT MET the required performance metric.

| CL# | Compliance Indicator Requirement | Evidence in DBHDS's submitted documentation | Status | | Factual verification and analysis |
|---|---|---|---|---|---|
| | | | MET | NOT MET | |
| 33.13 | 86% of unexplained/ unexpected deaths reported through DBHDS incident reporting system have a completed MRC review within 90 days of death | The SFY23 Mortality Review Committee Charter documents the definition of unexpected death. See ATTACHMENT 1. | X | | This study verified that DBHDS achieved the requirements of Compliance Indicator 33.13. See Attachment 2 and 3. The MRC made marked improvement achieving the performance measure for this indicator beginning in February 2023, which reviewed deaths from October 2022. Until then, the MRC was catching up with past reviews. Having fully caught up with its backlog, the MRC completed 88% of mortality reviews within 90 days (cumulative compliance) and Met the requirements of this indicator for the 22nd and 23rd review periods (November 2022 – August 2023). |
| 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. If the MRC elects not to make any recommendations, it must affirmatively state that no recommendations were warranted." | 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." See Attachment 4 for content review of the MRC Quarterly Reports to the Commissioner. | X | | This study verified that DBHDS completed and submitted quarterly reviews to the Commissioner for both quarters during the 22nd and the first quarter of the 23rd review periods. These quarterly reports included the deliberations, findings, and recommendations, as required. They each stated affirmatively if no recommendations were warranted.<br><br>These three consecutive quarterly reports included 88% of unexpected deaths, which exceeded the 86% required. However, the quarterly breakdown was 94%, 94% and 77%. For the third quarter, there was a small number of unexpected deaths and an average number of older cases to review, which impacted the quarterly %, as it fell below the 86% benchmark.<br><br>It is this reviewer's opinion that the MRC achieved the indicator 33.15 for the content and overall percentage of unexpected deaths reviewed. |

| | | | | | |
|---|---|---|---|---|---|
| 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." | X | | This study verified that DBHDS achieved the requirements for this sub Compliance Indicator of 33.15.<br><br>For each MRC meeting, a 'DBHDS MRC Meeting Notes Summary' report documented whether a recommendation was made or not made/not considered applicable for each case reviewed. |
| 36.1 | Curative Action compliance: validation of provided data | Data Set Attestations were submitted for the data set: MRC Master Document Posting Schedule , Process Name: DBHDS MRO Process Document updated February 2023. This included documented review by the Accountable Executive, the Data Analyst review process for data set and visualization validation, , and Chief Data Officer review summary, with attestation signed by the Chief Information Officer. | X | | This study verified that DBHDS achieved the requirements for this Compliance Indicator concerning the mortality review process.<br>Data Set Attestation Form confirmed the MDPS review for the months of October – December 2022. This indicated compliance with this indicator for the 22nd Review Period.<br><br>For the 23rd Review period, The Data Set Attestation Form included an 'Accountable Executive Review Summary', 'Preparatory to Research' brief description of MRC purpose and scope, process, basis for interventions, action and outcomes, and electronic database tracking and data validation. Data set and visualization validation utilized from MS excel spreadsheets named "MRC Death Data from 2.2023-7.31.2023". No errors or defects were found.<br>The Chief Data Officer Review summary attested that the data was representative of the data intended to be collected, and processes followed were reliable and valid. |
| | Attestation document signed. | Data Set Attestation Form included the signature of the Chief Information Officer. | X | | This study verified that DBHDS achieved the requirements for this Compliance Indicator of 36.1 concerning the mortality review process. A Data Set Attestation Form was submitted with the signature of the Chief Information Officer, dated 4/3/23 at 0910hr EDT, attesting to reliability and validity of the data for |

| | | | | | |
|---|---|---|---|---|---|
| | | | | | the October through December 2022 MDPS. This data would be reviewed.<br>A more recent Data Set Attestation Form was submitted with the signature of the Chief Information Officer, dated 10/17/23 at 1355hr EDT, attesting to the reliability and validity of the data for the MRC Death Data from 2.2023 -7/31/2023. |

ATTACHMENTS for 22nd and 23rd Review Period

ATTACHMENT 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. An unexplained death is considered an unexpected death."

COMPLIANCE INDICATOR 33.13

ATTACHMENT 2: Virginia unexpected death data 22nd review period:

Deaths during any one month were reviewed in the timeframe of 1-3 consecutive MRC meetings. Included in these reviews were the following deaths that occurred during the 22nd review period:

| **Calendar month of deaths** | **# unexpected deaths reviewed** | **Compliance ratio** (# w/i 90 days/# reviewed) | **Cumulative compliance** |
|---|---|---|---|
| October 2022 | 7 | 0/7 | 0/7 |
| November 2022 | 6 | 5/6 | 5/13 |
| December 2022 | 10 | 10/10 | 15/23 |
| January 2023 | 14 | 13/14 | 28/37 |
| February 2023 | 12 | 11/12 | 39/49 |
| March 2023 | 8 | 8/8 | 47/57 |
| Compliance with 90 day time period | | | 82% |
| Compliance with 90 day time period November 2022 through March 2023 | | 47/50 | 94%* |

*The "catch up" period appeared to end in October 2022. Excluding this month, the compliance with the 90 day time period for review was 46/49=94%.

ATTACHMENT 3: Virginia unexpected deaths, 23rd period review:

| Calendar month of deaths | # unexpected deaths reviewed | Compliance ratio | Cumulative compliance |
|---|---|---|---|
| 4/13/23 | 9 | 8/9 | 8/9 |
| 4/27/23 | 6 | 6/6 | 14/15 |
| 5/11/23 | 7 | 7/7 | 21/22 |
| 5/25/23 | 4 | 3/4 | 24/26 |
| 6/8/23 | 5 | 5/5 | 29/31 |
| 6/22/23 | 2 | 2/2 | 31/33 |
| 7/13/23 | 5 | 3/5 | 34/38 |
| 7/27/23 | 6 | 6/6 | 40/44 |
| 8/10/23 | 5 | 4/5 | 44/49 |
| 8/24/23 | 4 | 3/4 | 47/53 |
| 9/14/23 | 2 | 2/2* | 49/55 |
| 9/28/23 | 3 | 1/3 | 50/58=86% |

*MRC meeting occurred on the 91st day following 2 deaths; this was considered as compliant for this report, as review was awaiting MRC deliberation.

During this time period, the dates of deaths that were reviewed were from January 2023 to July 2023.

COMPLIANCE INDICATOR 33.15

ATTACHMENT 4: Mortality Review Committee Quarterly Reports, 22nd and 23rd Review Periods

For the 22nd and 23rd Review Periods, the Mortality Review Committee submitted a report for each of the three quarters. As required by compliance indicator 33.15, all of the quarterly Reports included recommendations for the specific provider agency as well as systemic recommendations based on database analysis for deaths during this time period. MRC meetings without recommendations were listed.

The cumulative compliance rate for deaths during calendar months November 2022 through June 2023 achieved the 86% threshold for Compliance Indicator 33.15, which included review of these deaths in the 'Quarterly Reports to the Commissioner' Q3 FY23 (deaths during Nov 2022 through March 2023), and Q4 FY23 (deaths from March through June 2023).

| Calendar month of deaths | Compliance ratio | Cumulative compliance |
|---|---|---|
| October 2022 | 0/7 | Not counted as this was during 'catch up phase' |
| November 2022 | 5/6 | 5/6 |
| December 2022 | 10/10 | 15/16 |
| January 2023 | 13/14 | 28/30 |
| February 2023 | 11/12 | 39/42 |
| March 2023 | 8/8 | 47/50 |
| April 2023 | 6/8 | 53/58 |
| May 2023 | 10/12 | 63/70 |
| June 2023 | 4/6 | 67/76=88% |

The reviewer found the following data for the 22nd and 23rd Review periods:

| Calendar month of death | # unexpected deaths reviewed | Compliance ratio | Cumulative compliance |
|---|---|---|---|
| October 2022 | 7 | 0/7 | 0/7* |
| November 2022 | 6 | 5/6 | 5/13 |
| December 2022 | 10 | 10/10 | 15/23=65% |
| Nov-Dec 2022 (removing 'catch up' period) | 16 | 15/16 | 15/16=94% |

*The "catch up" period appeared to end in October 2022. Excluding this month, the compliance with the 90 day time period for review was 46/49=94%.

| Calendar month of death | # unexpected deaths reviewed | Compliance ratio | Cumulative compliance |
|---|---|---|---|
| January 2023 | 14 | 13/14 | 13/14 |
| February 2023 | 12 | 11/12 | 24/25 |
| March 2023 | 8 | 8/8 | 32/34=94% |

| Calendar month of death | # unexpected deaths reviewed | Compliance ratio | Cumulative compliance |
|---|---|---|---|
| April 2023 | 6 | 6/8 | 6/8 |
| May 2023 | 12 | 10/12 | 16/20 |
| June 2023 | 6 | 4/6* | 20/26=77% |

*MRC meeting occurred on the 91st day following 2 deaths; this was considered as compliant for this report, as review was awaiting MRC deliberation.

# APPENDIX I

## Office of Licensing and Office of Human Rights

**by**

**Chris Adams, MS**

**TO:** Donald Fletcher, Independent Reviewer

**FROM:** Chris Adams

**RE:** 23rd Study Report: Office of Licensing/Office of Human Rights (OL/OHR)

**DATE:** October 30, 2023

## Introduction

Prior to initiation of the 23rd study of the requirements at Provision V.C.6, sufficient evidence supported that the Commonwealth achieved and sustained achievement of the requirements for the following five Compliance Indicators:

- 34.1 – 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.
- 34.2 – 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 included services associated with reporting requirements for i. Emergency room visits; and ii. hospitalizations.
- 34.3 – 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.
- 34.6 – DBHDS reviews and approves corrective action plans that are in response to serious incidents, abuse, neglect, or death in accordance with the Licensing and Human Rights Regulations. DBHDS follows up on approved corrective action plans to ensure that they have been implemented and are achieving their intended outcomes as follows: a. For serious injuries and deaths that result from substantiated abuse, neglect, or health and safety violations, the Office of Licensing verifies that corrective action plans have been implemented within 45 days of their start date. b. In cases of substantiated abuse or neglect that do not involve serious injury or death, the Office of Human Rights verifies that corrective action plans have been implemented within 90 days of their start date. c. On an annual basis, at least 86% of corrective action plans related to substantiated abuse or neglect, serious incidents, or deaths are fully implemented as specified in this indicator, or if not implemented as specified, DBHDS takes appropriate action as determined by the Commissioner in accordance with the Licensing Regulations.
- 34.7 – Providers including CSBs, that have recurring deficiencies in the timely implementation of DBHDS-approved corrective action plans relating 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.

The focus of the 23rd study is on the following Compliance Indicators:

- 34.4 – At least 86% of reportable serious incidents are reported within the timelines set out by DBHDS policy.
- 34.5 – Providers, including CSBs, that fail to report serious incidents, deaths , or allegations of abuse or neglect as required by the Licensing Regulations receive citations and are required to develop and implement DBHDS-approved corrective action plans.
- 34.8 – DBHDS has Polices or Departmental Instructions that specify requirements for Training Centers to report serious incidents, including deaths, or allegations of abuse or neglect and to implement and monitor corrective actions; that DBHDS has a process to monitor implementation of corrective actions; and when harms have not been reported in accordance with policies or Departmental instructions, an analysis is conducted to identify root causes resulting in corrective actions as necessary to address the identified causes.

## Summary of Findings 23rd Study

Findings from the 21st study determined that, for Compliance Indicators 34.4, 34.5, and 34.8, processes and procedures required by the Compliance Indicators had been developed and implemented. However, the documentation of the processes was not fully detailed and the reliability and validity of the data resulting from them had not been sufficiently validated. Prior to this study, DBHDS conducted an extensive review of these processes, developed detailed process descriptions for each of them, and conducted data verification procedures to attest that the data resulting from the processes were reliable and valid. The Risk Management Review Committee (RMRC) is responsible for the oversight of these processes, the ongoing review of data and information coming from them, and for recommending process improvements and corrective actions necessary to assure their ongoing viability. Based on review of those process documents, comparison of the descriptions with relevant Licensing and Office of Human Rights regulations, Virginia statutes, and relevant Departmental Instructions, there was sufficient documentary evidence to support that the processes required in these three Compliance Indicators are established, well-documented, operational, and are producing valid and reliable data and information upon which DBHDS can draw relevant conclusions and make objectively informed process revisions and improvements.

### Methodology

Following procedures employed in the 19th and 21st reviews, this Consultant reviewed documents and records (see Table 3) to evaluate evidence and substantiate the extent to which the Commonwealth has achieved or sustained achievement of Compliance Indicators 34.4, 34.5, and 34.8. The review included conducting virtual conversations with staff members knowledgeable about the processes, their implementation, and oversight (see Table 2) to clarify questions regarding the documentary evidence and offer the staff members additional opportunities to provide any information that would be helpful in reaching a conclusion about indicator achievements. The methodology also included review of incident data and information related to the 15,000+ incidents reported by licensed providers through the CHRIS system in CY2022 and the first six months of CY2023 and maintained and tracked through the CONNECT data system. From this review, there was sufficient evidence available to verify that the requirements of Compliance Indicators 34.4 and 34.5 are consistently documented and continue to be achieved.

### Process Documents & Attestations

For Indicators 34.4 and 34.5, a process document, ***29.3-29.5 34.4-34.7 LIC Asmt Incident Report Prov DS VER 005***, provides detailed descriptions of the roles and responsibilities of staff involved in the various process steps, a description of process modifications made over time, descriptions of the various reporting mechanisms, and details of the measurement criteria for those elements for which there is a specified data

threshold. The document also describes data validation reviews, mitigation strategies for issues identified from those reviews, and recommendations for source system modifications for future consideration. The numerator and denominator are correctly stated for the metric in Indicator 34.4 (86%). Accompanying this process document was an attestation statement, ***29.3-29.5 .4.4-34.7 Late Reporting Attachment B***, that describes the data validation procedures employed to review these processes and a statement that, based on these validation procedures, the processes were found to be thorough and detailed and that no data errors or issues were identified.

For Indicator 34.8, DBHDS submitted a process document, ***34.08 DOJ Process TC Incident Review VER004***, that provides a detailed description of all processes associated with identification, reporting, investigation, data analysis, and needed corrective actions relating to serious incidents, including deaths, or allegations of abuse or neglect reported by the Southeast Virginia Training Center (SEVTC). It also includes a description of the verification procedures the data analyst completed on 08/28/2023 that resulted in determination that the data specific to incidents of abuse/neglect entered into the CHRIS system are reliable and valid. Accompanying the process document was an attestation statement, ***34.8 TC Incident Data Attachment B 8.30.2023***, documenting verification of all of the process steps involved in incident reporting and implementing and monitoring corrective actions as needed. It also addresses verification by the data analyst that the specific processes for data entry, tracking, and analysis of data regarding allegations of abuse or neglect in the CHRIS system are reliable and valid.

### Compliance Indicator Achievement

Based on review of relevant documentary evidence, interviews with key staff at DBHDS, and verification of data relevant to Compliance Indicators 34.4, 34.5, and 34.8, there was sufficient evidence to conclude that the Commonwealth has achieved each of the requirements in these Compliance Indicators, that process descriptions related to data specific to the Compliance Indicators is well-documented, and that the resulting data has been determined to be valid and reliable.

### Table 1
### Compliance Indicator Table

Table 1 below details the facts, analysis, and conclusions drawn from the review of the Commonwealth's efforts to achieve and sustain the requirements of Provision V.C.6, Compliance Indicators 34.4, 34.5 and 34.8

| 23rd Study Findings |
|---|
| **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 pursuant to the DBHDS Human Rights Regulations (12VAC35-115-240), the DBHDS Licensing Regulations (12VAC35-105-170), Virginia Code §37.2-419 in effect on the effective date of this Agreement, and other requirements in this Agreement. |

| CI | Facts | Analysis | Conclusion(s) |
|---|---|---|---|
| **34.4:** On an annual basis, the Commonwealth determines that at least 86% of reportable | Data from CY2022 reflect that 96.13% of the 10,461 incidents were reported within the required 24-hour timeframe or were late based on a valid excuse. | DBHDS provided two data reports that included information for each incident that was reported during CY2022 (***34.4 34.5 DOJ 1.1.2022 to 12.31.2022 Late Reporting Data***) and 01/2023-06/2023 (***34.4 34.5 DOJ 1.1.2023 to 6.30.2023 Late*** | 21st – Met*<br>22nd – Met<br>23rd - Met |

| CI | Facts | Analysis | Conclusion(s) |
|---|---|---|---|
| serious incidents are reported within the timelines set out by DBHDS policy. | Data from the first six months of CY2023 reflect that 96.05% of the 5,209 incidents were reported within the required 24-hour timeframe or were late based on a valid excuse.<br><br>DBHDS provided a detailed Process Document (***29.3-29.5 34.4-34.7 LIC Asmt Incident Report Prov DS VER 005***) that includes description of all of the steps related to incident reporting from the provider through the CHRIS system and data transfer and analysis procedures in the CONNECT data system. The document describes mitigation strategies carried out by the OL IMU to address identified concerns with identified CHRIS system data inaccuracies and notes plans to procure a replacement for the CHRIS system through DBHDS procurement procedures.<br><br>The data specific to the calculation of the threshold required by this Compliance Indicator has been determined reliable and valid based on a detailed analysis conducted by the data analyst and review of detailed data reports completed by the Consultant. | ***Reporting Data***). The Consultant reviewed each of these reports and verified that the summary data calculations in each were accurate.<br>• In CY2022 (22nd study period), there were 11,275 incidents reported with 10,461 of those reported within the required 24-hour timeframe and 378 late reports waived for valid reasons. This equates to a 96.13% on-time reporting for CY2022.<br>• In the first six months of CY2023 (23rd study period), there were 5,209 incidents reported with 4,864 of those reported within the required 24-hour timeframe and 139 late reports waived for valid reasons. This equates to a 96.05% on-time reporting for CY2023.<br><br>DBHDS provided a Process Document (***29.3-29.5 34.4-34.7 LIC Asmt Incident Report Prov DS VER 005***) that details the process for identification of incidents reported late by the OL Incident Management Unit (IMU). The Process Document maps the provider's incident data entry into the CHRIS system; import of that data into the CONNECT data system; and review, analysis, and follow-up by the IMU staff. The determination of late reporting is calculated within the CONNECT data system and all late reports are flagged and placed into a queue on each business day for review by IMU staff. The Process Document also details procedures for identification of late reports by licensing specialists during annual licensing reviews or other investigations. The Process Document references OL internal quality assurance procedures through a structured look-behind process. Concerns regarding accuracy of CHRIS data feeding into the | |

| CI | Facts | Analysis | Conclusion(s) |
|---|---|---|---|
| | | CONNECT system are described along with mitigation strategies that center on the roles and responsibilities of the OL IMU staff to carefully review each incident reported on each business day. The document also includes information about a procurement that has been developed to replace the CHRIS system. An Attestation Statement (*29.3-29.5 .4.4-34.7 Late Reporting Attachment B*) describes data set visualization and validation procedures conducted by the data analyst. The data analyst reviewed the process descriptions contained in the Process Document and determined them to be thorough and detailed. The data analyst used calculated functions to conduct a cross check of data from the CHRIS and CONNECT systems relating to serious incident reporting and documented that no data errors or issues were identified.<br><br>Based on review of relevant CONNECT reports, the detailed Process Document, and the Attestation Statement provided relevant to data used to calculate the measurement required by this Compliance Indicator, the Consultant found the processes to be well-documented and the data reports, data calculation summaries, and analysis to be complete and accurate. Additionally, the Consultant determined that, based on detailed Process Document descriptions, the testing and attestation of the validity and reliability of the data used in this measure, and the data from CY2022 (22nd study period) and the first six months of CY2023 (23rd study period) that reflect on-time incident reporting at 96%, well above the 86% threshold for this Compliance | |

| CI | Facts | Analysis | Conclusion(s) |
|---|---|---|---|
| | | Indicator, there is sufficient evidence to conclude that the Commonwealth achieved the requirements of this Compliance Indicator in the 22nd study period and sustained that achievement in the 23rd period. | |
| **34.5:** Providers, including CSBs, that fail to report serious incidents, deaths, or allegations of abuse or neglect as required by the Licensing Regulations receive citations and are required to develop and implement DBHDS-approved corrective actions. | DBHDS has regulations in place at ***12VAC35-105-160.D.2*** and ***12VAC35-105-170*** that require providers, including CSBs, to report serious incidents, deaths, or allegations of abuse or neglect to DBHDS through the CHRIS data system within 24 hours of discovery and that if not reported within that timeframe without a valid reason, the provider is cited and required to develop and submit a corrective action plan.<br><br>DBHDS has documented the relevant process descriptions, quality assurance activities, and requirements for corrective actions relevant to this Compliance Indicator in a Process Document (***29.3-29.5 34.4-34.7 LIC Asmt Incident Report Prov DS VER 005***) and provided verification of validity and reliability of the data resultant from these processes in an Attestation Statement (***29.3-29.54.4-34.7 Late Reporting Attachment B***).<br><br>The Consultant's review of detailed data reports relevant to this Compliance Indicator, along with other documentary evidence detailed in the Analysis | ***12VAC35-105-160.D.2*** establishes the requirement that providers must report Level II and Level III serious incidents to DBHDS within 24 hours of discovery. Providers who report an incident outside the 24-hour timeframe without a valid reason are issued a citation requiring a corrective action plan following licensing requirements at ***12VAC35-105-170***.<br><br>DBHDS provided two data reports that included information for each incident that was reported during CY2022-22nd study period (***34.4 34.5 DOJ 1.1.2022 to 12.31.2022 Late Reporting Data***) and 01/2023-06/2023-23rd study period (***34.4 34.5 DOJ 1.1.2023 to 6.30.2023 Late Reporting*** Data) which noted for each incident whether or not it was reported within the required 24-hour timeframe and if not, whether the late reporting was the result of a valid excuse. Based on review of data that detailed information for 16,484 incidents that were reported during this 18-month timeframe, the Consultant determined that the process to identify and follow-up on incidents reported outside the required 24-hour timeframe is operational, consistently followed, and results in the provider having to develop a corrective action plan detailing how they will ensure timely reporting in the future.<br><br>As these processes are described in detail in the Process Document (***29.3-29.5 34.4-34.7 LIC Asmt Incident Report Prov DS VER 005***) | 21st – Met*<br><br>22nd - Met<br><br>23rd - Met |

| CI | Facts | Analysis | Conclusion(s) |
|---|---|---|---|
| | column, supports that DBHDS has achieved and sustained achievement of the requirements of this Compliance Indicator. | and their validity and reliability certified in the Attestation Statement (***29.3-29.5 .4.4-34.7 Late Reporting Attachment B***), there is sufficient evidence to determine that the requirements of this Compliance Indicator were achieved in the 22nd study period and sustained in the 23rd period. | |
| 34.8: DBHDS has Policies or Departmental Instructions that specify requirements for Training Centers to report serious incidents, including deaths, or allegations of abuse or neglect, and to implement and monitor corrective actions. (a) DBHDS has a process to monitor the implementation of corrective actions. (b) When DBHDS identifies that harms have not been reported in accordance with policies or Departmental Instructions, an analysis is conducted to identify root causes; DBHDS implements | Regulations at ***12VAC35-115-240*** and ***12VAC35-105-170***, the ***Virginia Code §37.2-419***, and ***DBHDS Departmental Instruction 401 (RM) 03*** establish requirements for Training Centers to report serious incidents, including deaths, or allegations of abuse or neglect, to analyze and identify root causes of process variances, and to implement and monitor corrective actions.<br><br>The Process Control document ***34.08 DOJ Process TC Incident Review VER004*** provides a detailed description of all processes associated with identification, reporting, investigation, data analysis, and needed corrective actions relating to serious incidents, including deaths, or allegations of abuse or neglect reported by SEVTC. It also includes a description of the verification procedures completed by the data analyst on 08/28/2023 that resulted in determination that the data specific to incidents of abuse/neglect entered into the CHRIS system are reliable and valid. | Findings from the 19th and 21st study reports confirmed that DBHDS has policies and departmental instructions that specify requirements for Training Centers to report serious incidents, including deaths, or allegations of abuse or neglect, and to monitor corrective actions. These rule and policy requirements. ***12VAC35-115-240***, ***12VAC35-105-170***, and ***Virginia Code §37.2-419***, remain operational.<br><br>***DBHDS Departmental Instruction 401 (RM) 03*** dated 09/01/2020 outlines detailed instructions for reporting serious incidents, including deaths, or allegations of abuse or neglect, and to implement and monitor corrective actions at facilities operated by DBHDS. The Departmental Instruction addresses the use of Root Cause or Plan-Do-Study-Act analysis processes when it is identified that harms have not been reported as required. The Departmental Instruction also includes the ***Algorithm for Review and Follow-up of Death and Injuries in DBHDS Facilities*** that provides a framework for the Risk Manager to initiate or confirm that appropriate staff have taken steps to implement corrective actions as necessary to address identified causes.<br><br>The Southeast Virginia Training Center (SEVTC) continues to submit comprehensive, data-based incident management system reports to the | 21st – Met*<br><br>22nd - Met<br><br>23rd - Met |

| CI | Facts | Analysis | Conclusion(s) |
|---|---|---|---|
| corrective action as necessary to address identified causes. | The *34.8 TC Incident Data Attachment B 8.30.2023* attestation statement documents verification of all of the process steps to report serious incidents, including deaths, or allegations of abuse or neglect, and to implement and monitor corrective actions as needed. It also addresses verification by the data analyst that the specific data entry, tracking, and analysis of data for allegations of abuse or neglect in the CHRIS system are reliable and valid.<br><br>Through review of three SEVTC quarterly data reports presented to the RMRC, there were no reporting issues identified during these sample periods that required corrective action.<br><br>Evidence presented supports that DBHDS has sustained achievement of the requirements of this Compliance Indicator and that data used to measure this achievement are reliable and valid. | Risk Management Review Committee (RMRC) on a quarterly basis.<br>For this study, the following sample SEVTC quarterly reports and related RMRC minutes were reviewed:<br>• Q4 2022, 08/15/2022<br>• Q1 2023, 11/21/2022<br>• Q4 2023, 07/24/2023<br>The sample SEVTC quarterly reports detail information about each of the risk trigger areas identified and tracked by the facility, analysis of relevant frequencies and circumstances, and descriptions and status of mitigation strategies implemented to address each of them when required. The reports also provide status updates on any quality improvement initiatives specific to the facility's incident management system. The associated RMRC minutes describe member discussions regarding the data analysis presented in the SEVTC reports and status of specific follow-up actions addressing risk thresholds that were met during the reporting period. There were no reporting issues identified during these sample periods that required corrective action.<br><br>DBHDS provided a Process Document (*34.08 DOJ Process TC Incident Review VER004*) that includes detailed descriptions of the processes and procedures that operationalize the reporting of serious incidents, including deaths, or allegations of abuse or neglect, and implementation and monitoring of corrective actions. It includes specific roles and responsibilities of SEVTC and Office of Human Rights (OHR) staff members related to these processes. Process Steps 1-4 in the document relate to reporting and follow-up for all types of incidents. | |

| CI | Facts | Analysis | Conclusion(s) |
|---|---|---|---|
| | | Process Steps 5-11 relate to reporting and follow-up for allegations of abuse or neglect. The remainder of the Process Document addresses the data entry for incidents involving allegations of abuse or neglect into the CHRIS system. It identifies and documents mitigation strategies addressing issues previously identified related to service mapping in the CHRIS system. The data management processes associated with entering allegations of abuse/neglect into the CHRIS system were reviewed and validated by the data analyst on 08/28/2023 noting that noted mitigation strategies that have been implemented assure the data are reliable and valid. The *34.8 TC Incident Data Attachment B 8.30.2023* attestation statement documents verification of all of the process steps to report serious incidents, including deaths, or allegations of abuse or neglect, and to implement and monitor corrective actions as needed. It also addresses verification by the data analyst that the specific data entry, tracking, and analysis of data for allegations of abuse or neglect in the CHRIS system are reliable and valid.<br><br>Based on verification that all procedural requirements in this Compliance Indicator continue to be operational, that the process steps for reporting serious incidents, including deaths, or allegations of abuse or neglect are operational, and that data specific to allegations of abuse or neglect entered into the CHRIS system are reliable and valid, sufficient evidence exists to determine that achievement of the requirements of this Compliance Indicator were achieved in the 22nd study period and sustained in the 23rd period. | |

**Recommendations:**
There are no recommendations regarding the three Compliance Indicators described above.

**Table 2**
**Interviews Conducted**

The Consultant conducted telephonic interviews or interviews through email correspondence with the following staff members knowledgeable about the processes relevant to the Compliance Indicators that are the focus of this study to clarify questions regarding the documentary evidence and to afford them additional opportunities to provide any information that would be helpful in reaching a conclusion about indicator achievements.

| Name | Title |
|---|---|
| Jae Benz | Director, Office of Licensing |
| Mackenzie Glassco | Associate Director of Quality and Compliance |
| Taneika Goldman | State Human Rights Director |
| Dev Nair | Assistant Commissioner, Division of Provider Management |
| Heather Norton | Assistant Commissioner, Developmental Services |

**Table 3**
**Documents and Records Reviewed**

20. 34.4 34.5 DOJ 1.1.2022 to 12.31.2022 Late Reporting Data
21. 34.4 34.5 DOJ 1.1.2023 to 6.30.2023 Late Reporting Data
22. 29.3-29.5 34.4-34.7 LIC Asmt Incident Report Prov DS VER 005
23. 29.3-29.5 .4.4-34.7 Late Reporting Attachment B
24. 12VAC35-105-160.D.2
25. 12VAC35-105-170
26. 12VAC35-115-240
27. Virginia Code §37.2-419
28. DBHDS Departmental Instruction 401 (RM)
29. 34.08 DOJ Process TC Incident Review VER004
30. 34.8 TC Incident Data Attachment B 8.30.2023
31. Algorithm for Review and Follow-up of Death and Injuries in DBHDS Facilities
32. SEVTC Quarterly Report Quality Council 4th Qtr FY 22
33. SEVTC Quarterly Report Quality Council 1st Qtr FY 23
34. SEVTC Quarterly Report Quality Council 4th Qtr FY 23
35. RMRC Minutes 7.24.2023

# APPENDIX J

## Provider Training

**by**

**Chris Adams, MS**

**TO:** Donald Fletcher, Independent Reviewer

**FROM:** Chris Adams

**RE:** 23rd Period Study Report: Provider Training

**DATE:** October 18, 2023

## Introduction

Prior to initiation of the 23rd study of the requirements at Provision V.H.1, the Commonwealth was found to have achieved and sustained achievement of the requirements in the following nine Compliance Indicators:

- 49.1 – DBHDS makes available an Orientation Training and Competencies Protocol that communicates DD Waiver requirements for competency training, testing, and observation of DSPs and DSP Supervisors.
- 49.5 – DBHDS make 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.
- 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.
- 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 developmental opportunities.
- 49.8 – DBHDS licensing regulations require DBHDS licensed providers, their new employees, contractors, volunteers, and students to be oriented commensurate with their function or job-specific responsibilities with commensurate documentation by the provider. The orientation must address nine specific requirements enumerated in the Compliance Indicator.
- 49.9 – The Commonwealth requires through the DBHDS Licensing Regulations 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 the ISP, including an individual's detailed health and safety protocols.
- 49.10 – The Commonwealth requires all employees and contractors without a clinical license who are responsible for medication administration to demonstrate competency of this set of skills under direct observation prior to performing the task without direct supervision.
- 49.11 – The Commonwealth requires all employees or contractors 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 the tasks with any individual service recipient.
- 49.13 – Consistent with CMS assurances, DBHDS in conjunction with DMAS QMR staff, reviews citations and makes results available to providers through quarterly provider roundtables.

The focus of the 23rd study is on the following Compliance Indicators. The requirements for each of these Compliance Indicators had not been achieved at the time of the 21st period study:

- **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 training must include seven specific components enumerated in the Compliance Indicator.
- **49.3** – DSPs and DSP Supervisors who have not yet completed training and competency requirements 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.
- **49.4** – At least 95% of DSPs and their supervisors receive training and competency testing per DMAS regulation 12VAC30-122-180.
- **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. The training must include five specific areas enumerated in the Compliance Indicator. Employee participation in training and developmental opportunities shall be documented and accessible to the department. DBHDS will take appropriate action in accordance with Licensing Regulations if providers fail to comply with training requirements required by regulation.

**Summary of Findings 23rd Study**

DSP and DSP Supervisor training and core competency requirements are codified at ***12 VAC 30-122-180*** which became effective 03/31/2021. In November 2021 recognizing concerns regarding the adequacy of the DMAS provider review process specific to these training and core competency requirements, the parties agreed to modifications in the process to utilize data and information from Quality Service Reviews (QSRs) to measure achievement of the requirements of Compliance Indicators 49.2, 49.3 and 49.4. Results from the 21st study determined that these process changes address each of the requirements of Compliance Indicators 49.2 and 49.3 and Curative Action #10 and provide objective data to measure the training threshold requirements at Compliance Indicator 49.4. However, at the time of the 21st review, all of the elements of the process had not been fully implemented.

The current study assessed whether there is sufficient evidence to determine if each of the requirements of Compliance Indicators 49.2, 49.3, and Curative Action #10 as well as production of valid and reliable data sufficient to achieve the 95% threshold required at Compliance Indicator 49.4 has been achieved. DBHDS provided a detailed description of the process to obtain data and information related to Compliance Indicators 49.2, 49.3, and 49.4 and a description of the verification, validation and testing processes completed by the data analyst on 09/12/2023. In response to issues noted in the testing, DBHDS reviewed and updated the process and documented a process improvement that allowed the data analyst to verify that the data produced in QSR Round 5 was reliable and valid. These process changes will be used in all subsequent QSR rounds. In response to questions regarding the generalizability of the QSR sample size in the 21st study, DBHDS worked with the QSR vendor and documented that, consistent with the sampling methodology for the other elements of the QSR process, DSPs are now randomly selected, and the number reviewed is a statistically significant sample.

The findings of the 21st study verified that DBHDS has a licensing requirement at ***12VAC35-105-450*** that contains the training policy requirements in Compliance Indicator 49.12. Additionally, licensing

requirements at *12VAC35-105-50, 100, 110, and 115* prescribe negative actions and sanctions that can be taken with providers with significant or re-occurring citations. There have been no changes to these requirements.

Based on review and analysis of the information provided for review, there is sufficient evidence that the requirements at Compliance Indicators 49.2 and 49.3 were achieved during the 22nd study period and sustained through the 23rd study period.

The Commonwealth has not achieved the requirement at Compliance Indicator 49.4 that at least 95% of DSPs and their supervisors receive training and competency testing per DMAS regulation 12VAC30-122-180. The measurement criteria established by DBHDS requires achievement of the 95% threshold for two measures: (1) percentage of provider agency staff meeting provider orientation and training requirements, and (2) percentage of provider agency DSPs meeting competency training requirements. Both have to be at or above 95% to achieve the threshold.

- In QSR Round 3 (21st study) completed in 06/2022, 90.4% met Measure #1 and 92.3% met Measure #2.
- In QSR Round 4 (22nd study) completed in 02/2023. 85.0% met Measure #1 and 92.8% met Measure #2.
- In QSR Round 5 (23rd study) completed in 08/2023, 77.8% met Measure #1 and 85.3% met Measure #2. Note that the data reported from QSR Round 3 and 4 was not verified as reliable and valid

DBHDS has also not been able to achieve the 86% threshold requirement at Compliance Indicator 49.12.

- During CY2022 (22nd study), 973/1156 licensed providers (84.17%) met the requirements at 12VAC35-105-450 during their annual licensing inspection.
- During the first six months of CY2023 (23rd study), 648/849 licensed providers (76.33%) met the requirements at 12VAC35-105-450 during their annual licensing inspection.

## Methodology

Procedures employed in this consultant's previous reviews were continued for the current study. These included reviewing documents and records (see Table 3) to evaluate evidence and substantiate the extent to which the Commonwealth has achieved or sustained achievement of the requirements in Compliance Indicators 49.2, 49.3, 49.4, and 49.12. Additionally, this consultant conducted virtual interviews and conversations with staff members knowledgeable about the processes, their implementation, and oversight (see Table 2) to clarify questions regarding the documentary evidence and to offer them additional opportunities to provide any information that would be helpful in reaching a conclusion about indicator achievements. The Consultant completed a sample review of 25 randomly selected provider records including policies and procedures and licensing inspection reports relevant to the requirements at Compliance Indicator 49.12 to determine whether findings specific to the requirements at 12VAC35-105-450 from the annual licensing inspection concurred with those determined from the sample review. The study also included review of process documents and attestation statements relevant to the data associated with Compliance Indicators 49.4 and 49.12. This review verified that these processes are well-documented and that the steps in each of the processes were tested by a data analyst who determined that the processes were accurately described and that the data resulting from the processes were reliable and valid.

## Process Documents & Attestations

At the time of the 21st study, the process to aggregate and analyze the data to measure achievement of the outcomes required in Compliance Indicator 49.2 and Curative Action #10 had not yet been finalized. For the 22nd and 23rd studies, DBHDS provided a detailed description of the process to obtain data related to Compliance Indicator 49.4 and a description of the verification, validation and testing of this process completed by the data analyst on 09/12/2023. In response to issues noted in the testing, DBHDS reviewed

and updated the process and documented a process improvement that allowed the data analyst to verify that the data produced in QSR Round 5 was reliable and valid. These process changes will be used in all subsequent QSR rounds. In response to questions regarding the generalizability of the QSR sample size in the 21st study, DBHDS worked with the QSR vendor and documented that consistent with the sampling methodology for the other elements of the QSR process, DSPs are now randomly selected, and the number reviewed is a statistically significant sample.

### Compliance Indicator Achievement

Based on review of relevant documentary evidence, interviews with key staff at DBHDS, and verification of data relevant to Compliance Indicators 49.2, 49.3, 49.4, and 49.12, following is a brief summary of Compliance Indicator achievement:

- For Compliance Indicator 49.2, there is sufficient evidence to support that the Commonwealth achieved the requirements of this Compliance Indicator in the 22nd study period but that data to support that determination was not verified by the data analyst for QSR Round 4. With the data analyst's verification of the data processes and data for QSR Round 5, the Commonwealth has achieved all of the requirements in Compliance Indicator 49.2 in the 23rd study period.
- For Compliance Indicator 49.3, the Commonwealth achieved the requirements of this Compliance Indicator in the 22nd study and sustained that achievement in the 23rd study.
- The Commonwealth has not yet achieved the requirements at 49.4 and 49.12 as the threshold requirements in each of these Compliance Indicators have not yet been achieved. The process descriptions provided specific to these Compliance Indicators are well-documented and the resulting data has been determined to be valid and reliable.

Table 1 below details the facts, analysis, and conclusions drawn from the review of the Commonwealth's efforts to achieve and sustain the requirements of Provision V.H.1, Compliance Indicators 49.2, 49.3, 49.4, and 49.12.

## Table 1
## Compliance Indicator Table

Table 1 below details the facts, analysis, and conclusions drawn from the review of the Commonwealth's efforts to meet and sustain the requirements of Provision V.H.1, Compliance Indicators 49.2, 49.3, 49.4, and 49.12.

| 23rd Study 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. |

| CI | Facts | Analysis | Conclusion(s) |
|---|---|---|---|
| **49.2:**<br>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- | Regulations at ***12VAC30-122-180*** (DMAS) address each of the seven requirements in this Compliance Indicator. These regulations went into effect on 03/31/2021.<br><br>Consistent with requirements from Curative Action #10, the Commonwealth expanded the QSR process to incorporate review of the elements required by this Compliance Indicator.<br><br>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 of the assessed areas.<br><br>The process to aggregate and analyze the data to measure achievement of the outcomes required in Compliance Indicators 49.2, 49.3, 49.4, and Curative Action #10 has been documented in a | DSP and DSP Supervisor training and core competency requirements are codified at ***12 VAC 30-122-180*** which became effective 03/31/2021. 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.<br><br>Recognizing concerns regarding the adequacy of the DMAS provider review process specific to these training and core competency requirements, the parties agreed to modifications in the process to utilize data and information from Quality Service Reviews (QSRs) to measure achievement of the requirements of Compliance Indicators 49.2, 49.3 and 49.4. These process modifications were codified in ***Curative Action #10*** approved by the parties on 11/19/2021. The additions to the QSR process include review of personnel/training records for a sample of provider staff, review of | 21st – Not Met<br><br>22nd – Met*<br><br>23rd - Met |

| CI | Facts | Analysis | Conclusion(s) |
|---|---|---|---|
| determination in alignment with CMS definitions); c. positive behavioral supports; d. effective communication; e. at a minimum, the following identified potential health risks of individuals with developmental disabilities and appropriate interventions: choking, skin care (pressure sores, skin breakdown), aspiration pneumonia, falls, urinary tract infections, dehydration, constipation, and bowel obstruction, change of mental status, sepsis, seizures, and early warning signs of such risks, and how to avoid such risks; f. community integration and social inclusion (e.g., community integration, building and maintaining positive relationships, being active and | Process Document ***DSP Comp Ver 005*** dated 08/28/2023 and related Attestation Statement ***49.2-49.4 DSP Competencies Attachment B 9.9.23*** dated 09/09/2023. This process description addresses all of the requirements in Compliance Indicators 49.2, 49.3, 49.4 and Curative Action #10 and the data collection, reporting and analysis procedures have been deemed reliable and valid for QSR Round 5 and subsequent QSR reviews. | 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.<br><br>The Consultant evaluated the implementation of these process changes during the 21st study and determined that they address each of the requirements of Compliance Indicators 49.2 and 49.3 and Curative Action #10 and provide objective data to measure the training threshold requirements at Compliance Indicator 49.4.<br><br>If a QSR reviewer determines that an employee was not observed to demonstrate a required competency or there is a "no" response to any of the three related questions in the Provider Quality Review (PQR) or the twelve related questions in the Person-Centered Review (PCR), the Reviewer completes and submits a Health, Safety and Wellbeing (HSW) alert noting the name of the employee for whom the competency was not verified. The provider and DBHDS receive notice of this finding specific to each employee for which there was a "no" response. DBHDS uses the data regarding the number of HSW alerts received to calculate the percentage compliance requirements at 49.4 below. This process was in place during QSR | |

| CI | Facts | Analysis | Conclusion(s) |
|---|---|---|---|
| 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.<br><br>**Curative Action #10 –** addition of QSR as a data source supplementing/ replacing the DMAS information. | | Rounds 3, 4 and 5.<br><br>At the time of the 21st study, the process to aggregate and analyze the data to measure achievement of the outcomes required in Compliance Indicator 49.2, 49.3, 49.4 and Curative Action #10 had not yet been finalized. For this study, DBHDS provided a detailed description of the data collection, analysis, and reporting procedures in a Process Document ***DSP Comp Ver 005*** dated 08/28/2023 and related Attestation Statement ***49.2-49.4 DSP Competencies Attachment B 9.9.23*** dated 09/09/2023. These documents describe all of the steps required to obtain data related to Compliance Indicators 49.2, 49.3, and 49.4 and a description of the process verification, validation, and testing process completed by the data analyst on 09/12/2023. In the analysis, the data analyst identified a number of inconsistencies between the data reported by the QSR vendor and what was recorded by DBHDS. In response, DBHDS reviewed and updated the process and documented a process improvement that allowed the data analyst to validate the data produced in QSR Round 5. These process changes will be used in all subsequent QSR rounds. The Attestation Statement also notes that "With the implementation of these strategies and because all data was cross checked with the vendor, the data can be deemed reliable and valid." This validation applies only to data from QSR Round 5 and subsequent QSR reviews.<br><br>In the 21st study report, the Consultant noted a concern that DBHDS had not substantiated that the sample size in the QSR review | |

| CI | Facts | Analysis | Conclusion(s) |
|---|---|---|---|
| | | process is sufficient to generalize to all DSPs and DSP Supervisors that provide waiver-funded services. In response to this concern, DBHDS noted in the Process Document and in the Attestation Statement that, consistent with the sampling methodology for the other elements of the QSR process, DSPs are now randomly selected, and the number reviewed is a statistically significant sample.<br><br>Based on review and analysis of the information noted above, there is sufficient evidence that the Commonwealth, as an element of the QSR reviews, has a documented process in place to require 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. This evidence supports a determination that the Commonwealth achieved the requirements in Compliance Indicator 49.2 and Curative Action #10 during the 22nd study period; however, the data from QSR Round 4 was not validated. With completion of the data validation for QSR Round 5. The Commonwealth has achieved all of the requirements of this Compliance Indicator without qualification. | |
| **49.3:**<br>DSPs and DSP Supervisors who have not yet completed training and competency requirements per DMAS regulation 12VAC30-122- | The regulations at ***12VAC30-122-180.A.2*** and ***12VAC30-122-180.B.4*** address requirements in this Compliance Indicator and Curative Action #10.<br><br>A standardized process to assess whether the | The regulations at ***12VAC30-122-180.A.2*** and ***12VAC30-122-180.B.4*** address requirements in this Compliance Indicator that qualified staff who have passed the knowledge-based test must work alongside any DSP or supervisor who has not yet passed the test and that health and safety related direct support skills contained in the competencies | 21st – Not Met<br><br>22nd - Met<br><br>23rd - Met |

| CI | Facts | Analysis | Conclusion(s) |
|---|---|---|---|
| 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.<br><br>Curative Action #10 – addition of QSR as a data source supplementing/replacing the DMAS information. | requirements are achieved is a part of the QSR review. This process includes providing responses to three questions in the PQR and twelve questions in the PCR.<br><br>The QSR Reviewer is required to issue an HSW alert if the answer to any of the three relevant questions in the PQR or any of the twelve relevant questions in the PCR are answered "no". | checklist will only be performed under direct supervision, including observations and guidance, of qualified staff until competence is observed and documented.<br><br>Each of these requirements is assessed in the most recent iteration of the QSR protocol utilized in QSR Rounds 4 and 5. The QSR reviewer must determine if there is documentation that the staff have completed training and competency requirements; observe staff delivering services to verify they appear competent in doing so; and for any staff member who has not yet completed training and competency assessment, assess whether there was evidence of oversight and monitoring by staff who have demonstrated competency until that individual can successfully demonstrate competency.<br><br>The implementation of the latest iteration of the QSR protocol change included process modifications that now meet each of the requirements of this Compliance Indicator and those in Curative Action #10. In the 21st study, it was noted that the QSR reviewer was not required to issue an HSW alert if the question related to this required supervision was answered "no." This was successfully resolved and the Process Document ***DSP Comp Ver 005*** dated 08/28/2023 describes the requirement that a "no" response on any of the three relevant questions in the PQR and any of the twelve relevant questions in the PCR requires completion of and HSW alert. | |
| **49.4:**<br>At least 95% of DSPs and their supervisors | ***12VAC30-122-180*** contains the regulatory requirements relevant to this Compliance Indicator | ***12VAC30-122-180*** requires that DSPs and DSP Supervisors providing services to individuals with developmental disabilities receive or | 21st – Not Met<br><br>22nd – Not Met |

| CI | Facts | Analysis | Conclusion(s) |
|---|---|---|---|
| receive training and competency testing per DMAS regulation 12VAC30-122-180. | and Curative Action #10.<br><br>Beginning with the 3rd round of QSR reviews in 11/2021, assessment of this measure was shifted from the DMAS Quality Management Review process to the QSR process conducted by the Health Services Advisory Group (QSR vendor).<br><br>DBHDS provided a detailed description of the data collection, analysis, and reporting procedures in a Process Document ***DSP Comp Ver 005*** dated 08/28/2023 and related Attestation Statement ***49.2-49.4 DSP Competencies Attachment B 9.9.23*** dated 09/09/2023. These documents provide a detailed description of the process to gather and analyze data relevant to the requirements of this Compliance Indicator and Curative Action #10 and document that the processes have been determined to produce valid and reliable data to inform calculations necessary to accurately measure the 95% threshold in this Compliance Indicator.<br><br>Based on data reported in the ***05/2023 Provider Data Summary***, the 95% compliance threshold was not achieved for either of the elements that comprise | 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.<br><br>The Commonwealth modified methodology to measure percentage compliance with this indicator, as stipulated in ***Curative Action #10*** approved by the parties on 11/19/2021, using data regarding the number of Health, Safety, and Wellbeing (HSW) alerts issued in response to three relevant questions in the Provider Quality Review (PQR) tool and twelve relevant questions in the Person-Centered Review (PCR) tool.<br><br>At the time of the 21st study, the process to aggregate and analyze the data to measure achievement of the outcomes required in Compliance Indicators 49.2, 49.3, 49.4 and Curative Action #10 had not yet been finalized. For this study, DBHDS provided a detailed description of the data collection, analysis, and reporting procedures in a Process Document ***DSP Comp Ver 005*** dated 08/28/2023 and related Attestation Statement ***49.2-49.4 DSP Competencies Attachment B 9.9.23*** dated 09/09/2023. These documents describe all of the steps required to obtain data related to Compliance Indicators 49.2, 49.3, 49.4, and Curative Action #10 and a | 23rd - Not Met |

| CI | Facts | Analysis | Conclusion(s) |
|---|---|---|---|
| | the determination of "met" for this Compliance Indicator in QSR Rounds 4 or 5. | description of the process verification, validation and testing process completed by the data analyst on 09/12/2023. In the analysis, the data analyst identified a number of inconsistencies between the data reported by the QSR vendor and what was recorded by DBHDS. In response, DBHDS reviewed and updated the process and documented a process improvement that allowed the data analyst to validate the data produced in QSR Round 5. These process changes will be used in all subsequent QSR rounds. The Attestation Statement also notes that "With the implementation of these strategies and because all data was cross checked with the vendor, the data can be deemed reliable and valid." Based on the Consultant's review of the Process Document and Attestation Statement, the process to gather and analyze data relevant to the requirements of this Compliance Indicator and Curative Action #10 is detailed, clearly described, and has been verified to produce valid and reliable data responsive to the measurements required in this Compliance Indicator for QSR Round 5 and subsequent QSR reviews.<br><br>The Process Document references two elements that are assessed to determine if the requirements of Compliance Indicator 49.4 are met. These elements are (1) percentage of provider agency staff meeting provider orientation and training requirements, and (2) percentage of provider agency DSPs meeting competency training requirements. The Process Document stipulates | |

<table>
<tr><th>CI</th><th>Facts</th><th>Analysis</th><th>Conclusion(s)</th></tr>
<tr><td></td><td></td><td>that both elements must be at the 95% threshold or higher for the requirements of this Compliance Indicator to be met.<br><br>Using the validated calculation methodology, neither of the elements achieved the 95% threshold in QSR Round 3 (21st study period), QSR Round 4 (22nd study period) and QSR Round 5 (23rd study period as described below:<br><br>
<table>
<tr><th></th><th>QSR R3</th><th>QSR R4</th><th>QSR R5</th></tr>
<tr><td>Req 1</td><td>511/565<br>90.4%</td><td>272/320<br>85.00%</td><td>235/302<br>77.81%</td></tr>
<tr><td>Req 2</td><td>1092/1133<br>92.3%</td><td>653/719<br>92.82%</td><td>492/577<br>85.27%</td></tr>
<tr><td colspan="4">Note: QSR data from Rounds 3 and 4 were not verified as reliable and valid.</td></tr>
</table>
Using data, findings, and recommendations from the QSR process, the Commonwealth should develop and implement intensive technical assistance, with increased monitoring of and reporting by providers that do not meet the regulatory requirements for DSPs and their supervisors to receive training and competency testing.</td><td></td></tr>
<tr><td>49.12:<br>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</td><td>DBHDS has regulatory requirements at 12VAC35-105-450 and 12VAC35-105-50, 100, 110 and 115 that address the requirements of this Compliance Indicator.<br><br>The 2022 and 2023 Annual Compliance Determination Charts provide detailed guidance to licensing specialists on how to assess compliance with these regulations.<br><br>DBHDS provided a Process Document (49.12 DOJ Process Provider</td><td>DBHDS has a licensing requirement at 12VAC35-105-450 that contains the training policy requirements in this Compliance Indicator. Additionally, licensing requirements at 12VAC35-105-50, 100, 110, and 115 prescribe negative actions and sanctions that can be taken with providers with significant or re-occurring citations.<br><br>The 2022 and 2023 Annual Compliance Determination Charts provide detailed guidance to licensing specialists on how to assess whether providers are meeting these requirements through review of the provider's training policy to ensure it contains all the required elements</td><td>21st – Not Met<br><br>22nd – Not Met<br><br>23rd – Not Met</td></tr>
</table>

| CI | Facts | Analysis | Conclusion(s) |
|---|---|---|---|
| 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.<br><br>DBHDS will take appropriate in action in accordance with Licensing Regulations if providers fail to comply with training requirements required by regulation. | ***Training Policy Requirements VER002***) and an Attestation Statement (***49.12 Provider Training Attachment B 8.31.23.***) that document whether the processes and data verification utilized to produce the numerator and denominator used for calculation of the 86% threshold established by this Compliance Indicator are met. The data analyst did not identify any errors in the data based on the analysis conducted.<br><br>The Consultant reviewed documentary evidence and licensing specialist determinations specific to the requirements at §450 and this Compliance Indicator in a sample of 25 licensed providers. The Consultant concurred with 100% of the determinations of the licensing specialists in the sample provider's most recent annual licensing inspection. For these 25 sample providers, licensing specialists determined that 20/25 (80%) met the requirements at §450. DBHDS provided two CONNECT data reports that detail findings by provider for the requirements at §450 during annual licensing inspections conducted during CY2022 (22nd study period) and for the first six months of CY2023 (23rd study period). | and review of training records to verify that each DSP/Supervisor in the sample has documentation of the required training.<br><br>DBHDS provided a Process Document (***49.12 DOJ Process Provider Training Policy Requirements VER002***) that includes detailed information about the data used to calculate the percentage required by this Compliance Indicator. It also outlines each of the quality control activities that occur to assure that data entered in the CONNECT system relative to this and all other licensing requirements are accurate. These include Office of Licensing (OL) look-behind sample reviews and reviews of data reports at multiple supervisor/management levels. The processes outlined in this document and the resulting numerator and denominator calculations were reviewed, checked, cross-checked, and confirmed by the data analyst on 08/30/2023 and there were no errors found. This determination was described in the Process Document and the Attestation Statement ***49.12 Provider Training Attachment B 8.31.23.*** An overall analysis of the CONNECT system was also conducted in 2023 and OL addressed source system concerns from this analysis with the vendor to identify and prioritize specific improvement tasks and projects. None of these improvement tasks and projects specifically relate to the data used for this measure.<br><br>The Consultant reviewed documents relevant to this Compliance Indicator for 25 sampled providers and concurred with 100% the determinations of compliance at | |

| CI | Facts | Analysis | Conclusion(s) |
|---|---|---|---|
| | In 2022, licensing specialists determined that 973/1156 licensed providers (84.17%) met these requirements. In the first six months of 2023, licensing specialists determined that 648/849 licensed providers (76.33%) met these requirements. Both of these percentages fall below the 86% threshold required by this Compliance Indicator. | §450 made by the licensing specialist for these sample providers. Of the 25 providers in the sample, the licensing specialist determined that 20/25 (80%) met the requirements at §450.<br><br>DBHDS produced two provider-specific data summaries that detail licensing specialist determinations for *12VAC35-105-450:*<br><br>• ***49.12 450 1.1.22-12.31.22 (9/1/23)*** details findings from all annual licensing inspections conducted in CY2022 (22nd study period). 973/1156 licensed providers (84.17%) met the requirements at 12VAC35-105-450 during this calendar year. This falls below the 86% threshold required by this Compliance Indicator.<br>• ***49.12 450 1/1/23-6.30.23 (8/30/23)*** details findings from all annual licensing inspections conducted in the first six months of CY2023 (23rd study period). 648/849 licensed providers (76.33%) met the requirements at 12VAC35-105-450 during this six-month period. This also falls below the 86% threshold required by this Compliance Indicator. | |

**Recommendations:**
There are no recommendations related to Provision V.H.1, Compliance Indicators 49.2, 49.3, 49.4, or 49.12.

## Table 2
## Interviews Conducted

The Consultant conducted telephonic interviews or interviews through email correspondence with the following staff members knowledgeable about the processes relevant to the Compliance Indicators that are the focus of this study to clarify questions regarding the documentary evidence and to afford them additional opportunities to provide any information that would be helpful in reaching a conclusion about indicator achievements.

| Name | Title |
|---|---|
| Eric Williams | Director, Office of Provider Network Supports |
| Jae Benz | Director, Office of Licensing |
| Mackenzie Glassco | Associate Director of Quality and Compliance |
| Dev Nair | Assistant Commissioner, Division of Provider Management |
| Heather Norton | Assistant Commissioner, Developmental Services |

## Table 3

## Documents and Records Reviewed

36. 12VAC35-122-180
37. Curative Action #10
38. DSP Comp Ver 005
39. 49.2-49.4 DSP Competencies Attachment B 9.9.23
40. 05/2023 Provider Data Summary
41. 12VAC35-105-450
42. 12VAC35-105-50, 100,110, and 115
43. 2023 Annual Compliance Determination Chart
44. 49.12 DOJ Process Provider Training Policy Requirements VER002
45. 49.12 Provider Training Attachment B 8.31.23
46. 12VAC35-105-450
47. 49.12 450 1.1.22-12.31.22 (9/1/23)
48. 49.12 450 1.1.23-6.30.23 (8/30/23)
49. Sample Review Documents from 25 Licensed Provider Inspections Completed between 01/01/2023-06/30/2023:
    a. Annual Risk Management Plan
    b. Annual Quality Improvement Plan
    c. Policies, procedures, tools, and protocols relevant to the Quality Improvement Plan
    d. Annual Systemic Risk Assessment

# APPENDIX K

## Quality and Risk Management, Regional Quality Councils, and Quality Improvement Programs

**by**

**Rebecca Wright, MSW, LICSW**
**Chris Adams, MS**

# Quality and Risk Management System 23rd 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. The related provisions are as follows:

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

**Section 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. Harm includes any physical injury, whether caused by abuse, neglect, or accidental causes.

**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.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 (CIs) 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.

For this 23rd Period review, the study served as a follow-up to previous studies that have been competed annually since 2017 regarding the status of the Commonwealth's achievements regarding these selected Quality and Risk Management System requirements and systems. For the 23rd Period reviews, the Parties have agreed to target the CIs that have not been Met twice consecutively in the two most recent reviews.

For the CIs that were not studied in the 22nd Period, the 23rd Period reviews covered a full year (i.e., the 22nd and 23rd Period. This approach allowed the Commonwealth to demonstrate achievement of these CIs in two consecutive Review Periods. The reviews of the CIs that were studied in the recently completed 22nd Period only included the 23rd Period (4/1/23 - 9/30/23).

The following summarizes the compliance status of the Provisions and Compliance Indicators under review as of the time this 23rd Period Report began:

| **Provision** | **CIs studied in the 23rd Period** | **Two most recent ratings (i.e., M, M* or NM)** |
|---|---|---|
| V.B. | 29.1 | NM-M* |
| | 29.2 | NM-M |
| | 29.4 | NM-M |
| | 29.8 | NM-M* |
| | 29.10 | NM-M* |
| | 29.13 | M*-NM |
| | 29.14 | NM-M* |
| | 29.16 – 29.18 | NM-NM |
| | 29.19 | NM-M |
| | 29.20 – 29.25 | NM-NM |
| | 29.26 | NM-M* |
| | 29.27 | NM-M |
| | 29.28 – 29.30 | NM-M* |
| | 29.33 | NM-M* |
| V.C.1. | 30.4 | NM-NM |
| | 30.7 | NM-M |
| | 30.10 | NM-NM |
| | 30.11 | NM-M |
| V.C.4. | 32.3 | NM-M |
| | 32.4 | NM-NM |
| | 32.7 | NM-NM |
| V.D.1. | 35.1 | NM-NM |
| | 35.3 | NM-M* |
| | 35.5 | NM-NM |
| | 35.6 | NM-M |
| | 35.7 | NM-NM |
| | 35.8 | NM-M* |
| V.D.2.a.-d. | 36.1 | NM-NM |
| | 36.2 | M*-M* |
| | 36.3 | NM-NM |
| | 36.4 | NM-M* |
| | 36.5 | NM-NM |
| | 36.6 | NM-M |
| | 36.7 | M*-M* |
| | 36.8 | NM-NM |
| V.D.3. &V.D.3.a.-h. | 37.1 | M*-M* |
| | 37.2 | NM-M |
| | 37.5 & 37.6 | NM-M* |

| Provision | CIs studied in the 23rd Period | Two most recent ratings (i.e., M, M* or NM) |
|---|---|---|
| | 37.7 | NM-NM |
| | 37.10 | M*-M* |
| | 37.12 | M*-M* |
| | 37.14 | M*-M* |
| | 37.16 | M*-M* |
| | 37.17 | NM-M |
| | 37.18 | M*-M* |
| | 37.20 | M*-M* |
| | 37.22 | M*-M* |
| | 37.24 | M*-M* |
| V.D.4. | 38.1 | NM-NM |
| V.D.5. | 39.4 & 39.5 | NM-M* |
| V.D.5.b. | 40.2 | M*-M* |
| | 40.5 | NM-M* |
| | 40.7 | NM-M |
| V.E.1. | 42.3 – 42.4 | NM-NM |
| | 42.5 | NM-M |
| V.E.2. | 43.1 – 43.4 | NM-NM |
| V.E.3. | 44.1 | NM-NM |
| | 44.2 | NM-M* |

**Study Methodology:**
This study sought to gather and investigate facts and verify data and documentation provided by the Commonwealth to assess the sufficiency of the Commonwealth's actions to achieve and sustain achievement with each of the CIs described in the previous section. The methodology included 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, and verification that Virginia's relevant Process Documents and Attestations are complete.

Evidence gathering included:

- Review of documentary evidence provided by the Commonwealth specific to the requirements set out in each Indicator.
- A review of a sample of relevant records from 25 randomly selected licensed providers and Community Services Boards (CSBs) across the Commonwealth, review of data and information regarding the 11,275 Level II and Level III incidents reported by providers during CY 2022 and 5,209 Level II and Level III incidents reported by providers during the first six months of CY 2023, annual Office of Licensing (OL) inspection reports, and evidence packets that OL used in assessing regulatory compliance during the CY 2023 annual licensing inspection and review and analysis of any data from sources that DBHDS determined to be valid and reliable as well as other available data from the QSR process.
- Review of any changes that have been made to policies, procedures, and/or practices relating to the requirements in the applicable Compliance Indicators listed above.
- For CIs that rely on data to demonstrate compliance, the data validation process included review and analysis of documents described above for each CI focusing on:

a. Threats to data integrity previously identified by DBHDS assessments.
b. Actions taken by DBHDS that resolved these problems including completion dates for those activities.
c. Review of the verification process that DBHDS completed that confirmed that the data reported is reliable and valid.
d. The date when the Commonwealth's Attestation that the Process Document was properly completed, that the threats were sufficiently mitigated, and that the data reported are reliable and valid.

- Where the Parties had agreed to Curative Actions relevant to any of these Compliance Indicators as of the date of this proposal, the study also reviewed the current status of implementation.
- Interviews with key DBHDS staff.

**Summary of Findings:**

**Section V.B:**
DBHDS continued to have a robust set of policies, procedures and practices for quality improvement, as well as for quality assurance and risk management, but previous reports have stressed that having valid and reliable data was a crucial pre-requisite to a functional QMS and frequently documented deficiencies in this area. As described in previous reports, on 1/21/22, the Parties jointly filed with the Court an agreed-upon *Curative Action for Data Validity and Reliability*. It stated that DBHDS would continue to review data sources and update the quality management plan annually as required, including recommendations around actionable items for the systems to increase their quality and a deep dive into each source system every 3-5 years to test and follow the data and to review and identify source system threats to data reliability and validity.

The *Curative Action for Data Validity and Reliability* includes two elements: The first requires DBHDS to continue to complete periodic assessments of its data source systems, including the identification of threats to data validity and reliability and actions taken to mitigate those threats. The second 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 OCQM, that office is responsible for identifying the threats to data validity and reliability in the data collection methodologies. The *Curative Action for Data Validity and Reliability* describes creation of a Process Document that, among other things, for each applicable purpose 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 Chief Data Office (CDO) completes a review and attests that the process will produce valid and reliable data. This is known as the Data Set Attestation.

For the 23rd Period, and as described throughout this study, despite some remaining needs for enhancements, DBHDS efforts overall sufficiently demonstrated they met the requirements for data validity and reliability described in the *Curative Action for Data Validity and Reliability*. DBHDS consistently submitted more complete Process Documents and Data Set Attestations to evidence this. For example, with regard to serious incident reporting, DBHDS submitted sufficient factual evidence to show it addressed all previously identified specific threats to the reliability and validity of data derived from the CHRIS and CONNECT data source systems, as well as specific steps to achieve needed remediation. As a result of these overall efforts, the Commonwealth fully met many CIs that were only conditionally met at the time of the 22nd Period. For Section V.B, this included the following CIs: 29.1, 29.8, 29.10, 29.14, 29.26, 29.28, 29.29, 29.30 and 29.31.

Despite the improvements for serious incident reporting, some deficiencies remained. For example, requirements to complete look-behind reviews of serious incident and ANE data were not yet met, although DBHDS has made progress. The implementation of the VCU IMU look-behind process required at CI 29.16 has continued and results provide OL with significant information about issues/process improvements requiring specific attention. To date, the corrective actions and process modifications have resulted in notable improvements in the incident triage process, provider actions to assure immediate health/safety protection, and appropriate follow-up from the IMU Unit when necessary. Inclusion of a methodology to assess whether providers are implementing timely, appropriate corrective action plans when indicated has only recently been initiated so results have not yet been assessed. The look-behind review of reported allegations of abuse, neglect, and exploitation required at CI 29.17 was implemented in Q3 FY23 and results from two quarterly reviews were presented to the RMRC in 08/2023. As this process has only recently been implemented, there has not yet been sufficient time for the RMRC to have sufficient data and information available to identify and review trends, recommend quality improvement initiatives when necessary, and track implementation of initiatives approved for implementation.

In addition, for CI 29.24 (i.e., at least 95% of individual service recipients are adequately protected from serious injuries in service settings), DBHDS still needed to ensure the measure methodology would produce valid and reliable data and that DBHDS has sufficient data capabilities to allow for an adequate evaluation of serious injury data. Based on a SFY23 CHRIS report, for some 6410 ER visits and 1677 unplanned hospitalizations, DBHDS could not define the cause. In interview, DBHDS staff acknowledged that this could an unknown number of serious injuries. They also reported that some of this functionality was still being developed.

In the area of the training and technical assistance, DBHDS made resources available to providers specific to expectations for and processes to conduct thorough root cause analyses (RCAs) that has proven to be effective. This study's sample of 42 RCAs completed by providers during CYs 2022-2023 noted continued improvement in the quality and utility of these analysis processes compared to a similar review during the 22nd period study. Likewise, the Office of Clinical Quality Management was expanding its robust Consultation and Technical Assistance (CTA) Framework, including the very successful CTA practices specific to Office of Licensing (OL) quality improvement regulations.

**Section V.C.1:**
During the first six months of CY2023, the Office of Licensing conducted 747 licensing inspections and assessed all applicable licensing requirements at *12VAC35-105-520a-e* in 98.4% of the inspections. This was a 4% increase over the number assessed in CY2022. However, the current assessment process still does not sufficiently evaluate all of the requirements at CI 30.4. This also prevented DBHDS from meeting the requirements for CI 30.10. In the 22nd review, licensing inspection reports for 50 providers were sampled and, specific to the requirements at CI 30.4, the Consultant agreed with the licensing specialist findings in only 15% of the inspections. For this 23rd review, a similar comparative analysis reflected increased agreement to 52%, but this was still not sufficient to validate that licensing specialists are consistently and accurately assessing whether provider are meeting the regulatory requirements at *§520.C.5* and this Compliance Indicator. The Office of Licensing has continued to provide training and technical assistance to providers and to licensing specialists regarding these requirements and should continue to do so and consider increasing targeted quality assurance reviews to measure whether these efforts are improving the accuracy of the licensing specialist assessments of compliance with the requirements at CI 30.4. The Commonwealth continued to meet the requirements for CI 30.7 and 30.11.

**Section V.C.4:** DBHDS met CI 32.3 and CI 32.4, the latter for the first time. These CIs require providers to demonstrate that they complete training as part of their corrective action plan process when inspections determined they were non-compliant with risk management requirements, requirements about training and expertise for staff responsible for the risk management function and and/or requirements about conducting root cause analyses. To show they met the requirements for CI 32.7 and used risk management data to identify and implement needed training in these areas, DBHDS provided documentation of the implementation of RMRC procedures to 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. DBHDS provided RMRC meeting minutes that reflected related agenda items, discussions, presentations and action items. In addition, DBHDS continued to subsequently develop and post substantial guidance for providers and others on its website related to risk management (e.g., the OIH and OL webpages).

**Section V.D.1:** DBHDS made progress with previous deficiencies related to data validity and reliability, providing sufficient Process Documents and applicable Data Set Attestations for each Waiver Performance Measure, and continued to document that DMAS appropriately provided administrative oversight for the DD Waivers in compliance with its CMS-approved waiver plans. However, DBHDS did not meet the requirements for several CIs because the Commonwealth did not meet to review quarterly data or to develop and/or monitor needed remediation, as required in the Quality Improvement Systems (QIS) outlined in Appendix H for each of the HCBS Waivers. DBHDS reported that the QRT had undergone a transfer of ownership from DBHDS to DMAS and therefore no QRT meetings had occurred during this period of transition. This was reflected in continuing Not Met status for CI 35.1 and CI 35.5, but also resulted in the loss of the conditionally met (M*) status for CI 35.3. DBHDS also did not meet CI 35.8 (i.e., at least 86% of individuals who are assigned a waiver slot are enrolled in a service within 5 months), which had been conditionally met for the 21st Period, because the most recently reported data showed performance at only 83%. The Commonwealth also did not meet the requirements for CI 35.7 because DBHDS did not provide evidence to show a local level or Community Service Boards (CSB) review, at least annually, of the Waiver Performance Measures.

**Section V.D.2 a-d:** Due to substantial improvements in data reliability and validity, DBHDS met many CIs that were only conditionally met at the time of the 21st Period. These included the following CIs: 36.2, 36.4, 36.6, and 36.7. DBHDS also met CI 36.1, CI 36.3 and CI 36.5 for the first time. DBHDS issued the *Data Quality Monitoring Plan Source System Report*, dated 9/28/23. Overall, the source system assessments for 16 source systems included a thorough narrative description of the improvements DBHDS indicated staff had made and identified actionable recommendations for improving any remaining threats to data quality. With regard to the QSR data source system, DBHDS finalized the *External Data Validation Checklist*, and while this did not fully address previously identified concerns, this study determined that, in its finished state, it at least minimally met the requirements of the *Curative Action for Data Validity and Reliability*. However, the study found some remaining concerns that DBHDS should address going forward. Chief among these was the failure of the assessment to address potential inter-rater reliability (IRR) deficiencies and their impact on data validity and reliability. Previous Reports to the Court have repeatedly identified these concerns and provided multiple examples of discrepancies between the data findings of the QSR reviewers and those of the Independent Reviewer's consultants. DBHDS should also further examine the Process Documents and Data Set Attestations for any QSR data set to ensure they have adequately identified and addressed the IRR threats.

The Commonwealth did not meet the requirements of CI 36.8 because DBHDS made several potentially significant modifications to the previously proposed methodology that not only could impact the validity of the sample, but also did not appear to fulfill the corrective action requirements of the CI. DBHDS made this information available with only one month remaining in the 23rd Period, so there was not sufficient time for the Independent Reviewer to investigate and verify the data quality.

**Section V.D.3:** Due to substantial improvements in data reliability and validity, the Commonwealth met all of the CIs for this Provision, including 12 that were previously conditionally met and one that was not met.

**Section V.D.4:** DBHDS continued to collect and utilize data from all the identified source systems identified in this Provision's single CI. In addition, as described above, they achieved substantial improvement with regard to ensuring data validity and reliability, including at least minimally adequate source system assessments. As a result, the Commonwealth met the requirements of this CI for the first time.

**Section V.D.5, 5.a and 5.b:** Again due to substantial improvement with regard to ensuring data validity and reliability, for four CIs (i.e., CI 39.4, CI 39.5, C1 40.2 and CI 40.5), the Commonwealth fully met the requirements for the first time, and continued to meet the requirements for CI 40.7

**Section V.E.I:** DBHDS continued to meet the requirements for CI 42.5, which require policies or Departmental Instructions that require Training Centers to have quality improvement programs. For CI 42.3, DBHDS demonstrated that 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 and met those requirements.

However, DBHDS did not meet CI 42.4, because during FY23, 86% of DBHDS-licensed providers were compliant with only six of *VAC 35-105-620's* 11 sub-regulations. DBHDS provided a Process Document and Data Set Attestation that sufficiently reconciled concerns with the methodologies found during 21st Period. In summary, at that time, the calculation for the denominator excluded providers who had an unannounced licensing inspection within the year, but for whom the inspection did not fully review compliance with 12 VAC 35-105- 620. In other words, their compliance status was unknown. This had the potential to skew the resulting data reports since the denominator for the measure was not 100% of the providers that had annual licensing inspections, but rather a lower percentage. Given the very high compliance with CI 42.3 (i.e., ranging from 93%-96% over the last six quarters), the data discrepancy for this 23rd Period was not substantial. However, if compliance with CI 42.3 were to drop significantly, the impact on the data validity for this CI would be magnified. It is unlikely that such a significant drop will occur in the future, given the regulatory requirements that require DBHDS to assess provider compliance with 12 VAC 35-105- 620 during their annual inspections. However, to ensure the data continue to be sufficiently representative, DBHDS might consider modifying the Process Document to require that the denominator must always be of sufficient size to reach a 95% confidence level for all providers who had an annual unannounced inspection during the year.

**Section V.E.2:** The Commonwealth met the requirements for the remaining three CIs for this Provision (i.e., CI 43.1, CI 43.3 and CI 43.4), each for the first time. Pursuant to the relevant Curative Action, dated 11/9/21, DBHDS continued to collect and report data for 12 surveillance measures related to negative aspects of health and safety that come from provider critical incident reporting, and to collect and report data for community integration utilizing specific questions on the Provider Qualifications Review (PQR) Tool. On 8/27/23, DBHDS sent providers of developmental disability services a memorandum describing expectations regarding provider risk management programs and provider reporting measures, as well as links to appropriate tools that specified the parameters for collecting this data. Overall, the data collection and reporting at least minimally conformed with the requirements of the *Curative Action for Data Validity and Reliability*. However, it should be noted that some concerns remained with regard to the adequacy of the QSR IRR process, and its potential impact on QSR data validity and reliability. DBHDS should further examine the related Process Documents and Data Set Attestations for this QSR data set to ensure they have adequately identified and addressed the IRR threat.

**Section V.E.3:** The Commonwealth met the requirements for CI 44.1 (i.e., to use the QSR to assess provider quality improvement programs) for the first time. DBHDS continued to use the PQR tool, which included six elements relevant to the determination of the adequacy of providers' quality improvement programs. Overall, this study found that DBHDS and the QSR vendor had sufficiently enhanced the guidance and evaluation criteria for use by reviewers when making determinations. With regard to data validity and reliability, DBHDS provided both a Process Document a Data Set Attestation, as required. As described above, however, DBHDS should further examine these documents to ensure they have adequately identified and addressed the IRR threat. This study's sample of documents from a set of provider findings was not large enough to generalize the results, but there were some discrepancies between the QSR reviewers' findings and the results of the sample review. On the other hand, this study found the Commonwealth did not meet CI 44.2 because the study could not confirm that any of 15 vendor-issued QIPs sufficiently addressed the quality improvement deficiencies or identified the needed remediation or need for technical assistance. While this sample size was still small, the finding was universal. This called the QSR data for this CI into question.

The tables below summarize the status of each CI studied for this report:

| **V.B Indicators:** | **Status** |
|---|---|
| 29.1 The Commonwealth's Quality Management System includes the CMS approved waiver quality improvement plan and the DBHDS Quality Management System. DBHDS Quality Management System shall:<br>a) Identify any areas of needed improvement;<br>b) Develop improvement strategies and associated measures of success;<br>c) Implement the strategies within 3 months of approval of implementation;<br>d) Monitor identified outcomes on at least an annual basis using identified measures;<br>e) Where measures have not been achieved, revise and implement the improvement strategies as needed;<br>f) Identify areas of success to be expanded or replicated; and<br>g) Document reviewed information and corresponding decisions about whether an improvement strategy is needed.<br>The DBHDS Quality Management System is comprised of the following functions:<br>a) Quality Assurance<br>b) Quality Improvement<br>c) Risk Management- | **Met** |
| 29.4 The Office of Licensing assesses provider compliance with the serious incident reporting requirements of the Licensing Regulations as part of the annual inspection process. This includes whether the provider has conducted at least quarterly review of all Level I serious incidents, and a root cause analysis of all Level II and Level III serious incidents. The root cause analysis, when required by the Licensing Regulations, includes (a) a detailed description of what happened' (b) an analysis of why it happened, including identification of all identifiable underlying causes of the incident that were under the control of the provider; and (c) identified solutions to mitigate its recurrence. | Met |
| 29.8 The Office of Clinical Quality Improvement oversees and directs contractors who perform quality review processes for DBHDS including the Quality Services Reviews and National Core Indicators. Data collected from these processes are used to evaluate the sufficiency, accessibility, and quality of services at an individual, service, and systemic level. | **Met** |
| 29.10 The QIC sub-committees report to the QIC and 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. The QIC sub-committees evaluate data at least quarterly, identify at least one CQI project annually, and report to the QIC at least three times per year. | **Met** |
| 29.13 The RMRC reviews and identifies trends from aggregated incident data and any other relevant data identified by the RMRC, including allegations and substantiations of abuse, neglect, and exploitation, at least four times per year by various levels such as by region, by CSB, by provider locations, by individual, or by levels and types of incidents. | Not Met |
| 29.14 The RMRC uses the results of data reviewed to identify areas for improvement and monitor trends. The RMRC identifies priorities and determines quality improvement initiatives as needed, including identified strategies and metrics to monitor success, or refers these areas to the QIC for consideration for targeted quality improvement efforts. The RMRC ensures that each approved quality improvement initiative is implemented and reported to the QIC. The RMRC will recommend at least one quality improvement initiative per year. | **Met** |

| V.B Indicators: | | Status |
|---|---|---|
| 29.16 | The RMRC conducts or oversees a look behind review of a statistically valid, random sample of DBHDS serious incident reviews and follow-up process. The review will evaluate whether: i. The incident was triaged by the Office of Licensing incident management team appropriately according to developed protocols; ii. The provider's documented response ensured the recipient's safety and well-being; iii. Appropriate follow-up from the Office of Licensing incident management team occurred when necessary; iv. Timely, appropriate corrective action plans are implemented by the provider when indicated. v. The RMRC will review trends at least quarterly, recommend quality improvement initiatives when necessary, and track implementation of initiatives approved for implementation. | Not Met |
| 29.17 | The RMRC conducts or oversees a look-behind review of a statistically valid, random sample of reported allegations of abuse, neglect, and exploitation. The review will evaluate whether: i. Comprehensive and non-partial investigations of individual incidents occur within state-prescribed timelines; ii. The person conducting the investigation has been trained to conduct investigations; iii. Timely, appropriate corrective action plans are implemented by the provider when indicated. Iv. The RMRC will review trends at least quarterly, recommend quality improvement initiatives when necessary, and track implementation of initiatives approved for implementation. | Not Met |
| 29.18 | At least 86% of the sample of serious incidents reviewed in indicator 5.d meet criteria reviewed in the audit. At least 86% of the sample of allegations of abuse, neglect, and exploitation reviewed in indicator 5.e meet criteria reviewed in the audit. | Not Met |
| 29.19 | The Commonwealth shall require providers to identify individuals who are at high risk due to medical or behavioral needs or other factors that lead to a SIS level 6 or 7 and to report this information to the Commonwealth. | Met |
| 29.20 | At least 86% of the people supported in residential settings will receive an annual physical exam, including review of preventive screenings, and at least 86% of individuals who have coverage for dental services will receive an annual dental exam. | Not Met |
| 29.21 | At least 86% of people with identified behavioral support needs are provided adequate and appropriately delivered behavioral support services. | Not Met |
| 29.22 | At least 95% of residential service recipients reside in a location that is integrated in, and supports full access to the greater community, in compliance with CMS rules on Home and Community-based Settings. | Not Met |
| 29.23 | At least 95% of individual service recipients are free from neglect and abuse by paid support staff. | **Met** |
| 29.24 | At least 95% of individual service recipients are adequately protected from serious injuries in service settings. | Not Met |
| 29.25 | 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. | **Met** |

| **V.B Indicators:** | **Status** |
|---|---|
| 29.26 The Commonwealth ensures that at least 95% of applicants assigned to Priority 1 of the waiting list are not institutionalized while waiting for services unless the recipient chooses otherwise or enters into a nursing facility for medical rehabilitation or for a stay of 90 days or less. Medical rehabilitation is a non-permanent, prescriber-driven regimen that would afford an individual an opportunity to improve function through the professional supervision and direction of physical, occupational, or speech therapies. Medical rehabilitation is self-limiting and is driven by the progress of the individual in relation to the therapy provided. When no further progress can be documented, individual therapy orders must cease. | **Met** |
| 29.27 At least 75% of people with a job in the community chose or had some input in choosing their job. | Met |
| 29.28 At least 86% of people receiving services in residential services/their authorized representatives choose or help decide their daily schedule. | **Met** |
| 29.29 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. | **Met** |
| 29.30 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. | **Met** |
| 29.33 The Commonwealth ensures that individuals have choice in all aspects of their goals and supports as measured by the following: a. At least 95% of people receiving services/authorized representatives participate in the development of their own service plan. | **Met** |

| **V.C.1 Indicators:** | Status |
|---|---|
| 30.4. At least 86% of DBHDS-licensed providers of DD services have been assessed for their compliance with risk management requirements in the Licensing Regulations during their annual inspections. Inspections will include an assessment of whether providers use data at the individual and provider level, including at minimum data from incidents and investigations, to identify and address trends and patterns of harm and risk of harm in the events reported, as well as the associated findings and recommendations. This includes identifying year-over-year trends and patterns and the use of baseline data to assess the effectiveness of risk management systems. The licensing report will identify any identified areas of non-compliance with Licensing Regulations and associated recommendations. | Not Met |
| 30.7. DBHDS monitors that providers appropriately respond to and address risk triggers and thresholds using Quality Service Reviews, or other methodology. Recommendations are issued to providers as needed, and system level findings and recommendations are used to update guidance and disseminated to providers. | Met |
| 30.10 To enable them to adequately address harms and risks of harm, the Commonwealth requires that provider risk management systems shall identify the incidence of common risks and conditions faced by people with IDD that contribute to avoidable deaths (e.g., reportable incidents of choking, aspiration pneumonia, bowel obstruction, UTIs, decubitus ulcers) and take prompt action when such events occur or the risk is otherwise identified. Corrective action plans are written and implemented for all providers, including CSBs, that do not meet standards. If corrective actions do not have the intended effect, DBHDS takes further action pursuant to V.C.6. | Not Met |

| V.C.1 Indicators: | Status |
|---|---|
| 30.11 For each individual identified as high risk pursuant to indicator #6 of V.B, the individual's provider shall develop a risk mitigation plan consistent with the indicators for III.C.5.b.i that includes the individualized indicators of risk and actions to take to mitigate the risk when such indicators occur. The provider shall implement the risk mitigation plan. Corrective action plans are written and implemented for all providers, including CSBs, that do not meet standards. If corrective actions do not have the intended effect, DBHDS takes further action pursuant to V.C.6. | Met |

| V.C.4 Compliance Indicators | Status |
|---|---|
| 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. | **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. | **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 |
| 35.3 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 and monitoring of individual service plans, including choice of services and of providers, d. assurance of qualified providers, e. whether waiver enrolled individuals' identified needs are met as determined by DMAS QMR, f. identification, response to incidents, and verification of required corrective action in response to substantiated cases of abuse/neglect/exploitation (prevention is contained in corrective action plans). | **Not Met** |
| 35.5: 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 | Not Met |

| V.D.1. Compliance Indicators | Status |
|---|---|
| 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 | |
| 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. | **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 | **Not 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. | **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 information. | **Met** |
| 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. | **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 | **Met** |

| V.D.2 Compliance Indicators | Status |
|---|---|
| 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). | |
| 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. | **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, including Mortality Review Committee, Risk Management Review Committee, Case Management Steering Committee and KPA workgroups, establish performance measure indicators (PMIs) that are in alignment with the eight domains that are reviewed by the DBHDS Quality Improvement Committee (QIC). The components of each PMI are set out in indicator #5 of V.D.2. The DBHDS quality committees and workgroups monitor progress towards achievement of PMI targets to assess whether the needs of individuals enrolled in a waiver are met, whether individuals have choice in all aspects of their selection of their services and supports, and whether there are effective processes in place to monitor individuals' health and safety. DBHDS uses these PMIs to recommend and prioritize quality improvement initiatives to address identified issues | **Met** |
| 37.2: 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** |
| 37.5: 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 | **Met** |

| V.D.3 Compliance Indicators | Status |
|---|---|
| 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 | |
| 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. | **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** |
| 37.12: 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** |
| 37.14: 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** |
| 37.16: 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** |
| 37.20: The Community Inclusion/Integrated Settings KPA workgroup will develop, initiate, and monitor performance measures with a set target. Measures may be selected from, but not limited to, any of the following data sets: Employment; Community Engagement/Inclusion; QSRs; Housing; Regional Support Teams; Home and Community-Based Settings; NCI – (i.e., Individual Outcomes); WaMS | **Met** |
| 37.22: 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 | **Met** |

| V.D.3 Compliance Indicators | Status |
|---|---|
| Performance); WaMS; Individual and Family Support Program (IFSP); Provider Data Summary; QSRs | |
| 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 | **Met** |

| V.D.5 Compliance Indicators | Status |
|---|---|
| 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** |
| 40.2: 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** |
| 40.5: For each quality improvement initiative recommended by the RQC, at least one measurable outcome will be proposed by the RQC. | **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 | Met |

| V.D.5 Compliance Indicators | Status |
|---|---|
| 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. | |

| V.E.1 Compliance Indicators | Status |
|---|---|
| 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. | **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 analysis; d. Establish facility-wide quality improvement initiatives; and e. Monitor implementation and effectiveness of quality improvement initiatives. | **Met** |

| V.E.2 Compliance Indicators | Status |
|---|---|
| 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 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 | **Met** |
| 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 annually and update accordingly. | **Met** |
| 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. | **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. | **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. | **Not Met** |

## V.B. Analysis of 23rd Review Period Finding

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

| Compliance Indicator | Facts | Analysis | Conclusion |
|---|---|---|---|
| **29.1**<br>The Commonwealth's Quality Management System includes the CMS approved waiver quality improvement plan and the DBHDS Quality Management System. DBHDS Quality Management System shall:<br>a. Identify any areas of needed improvement.<br>b. Develop improvement strategies and associated measures of success.<br>c. Implement the strategies within 3 months of approval of implementation.<br>d. Monitor identified outcomes on at least an annual basis using identified measures.<br>e. Where measures have not been achieved, revise | Overall, DBHDS fulfilled the requirements of this Indicator.<br><br>Based on the *Developmental Disabilities Quality Management Plan State Fiscal Year 2024*, dated 8/13/23, the Commonwealth's Quality Management System (QMS) includes the CMS approved waiver quality improvement plan and the DBHDS Quality Management System.<br><br>The *Developmental Disabilities Quality Management Plan State Fiscal Year 2024* also documents that the DBHDS Quality Management System is comprised of the following functions: a. Quality Assurance, b. Quality Improvement and c. Risk Management. It also specifies responsibilities and defines the policies and procedures for | At the time of the 22nd Period, despite a robust set of policies, procedures and practices for quality improvement, as well as for quality assurance and risk management, the lack of valid and reliable data continued to be the primary challenge to a finding of full compliance. DBHDS had developed sufficient processes and practices to adequately use valid and reliable data, but had not yet implemented procedures to ensure such data existed.<br><br>For this 23rd Period, DBHDS again provided documentation to show the Quality Management System possessed the requisite policies, procedures and practices. This included the *Developmental Disabilities Quality Management Plan State Fiscal Year 2024*, dated 8/13/23. Similarly to the findings of previous reviews, the plan provided a clear overall conceptualization of the quality improvement structures and functions envisioned. It was comprised of two parts. *Part 1: The Quality Management (QM) Program Description* describes the current structure and framework for discovery and remediation activities and provides a path forward for improvement activities. *Part 1* also specifically describes the CMS approved waiver quality improvement plans and the role of the Office of Waiver Network Supports to work with the Department of Medical Assistance Services (DMAS) to collaboratively oversee implementation of these plans. *Part 2: The Quality Improvement Committees* describes the organization of all the quality improvement committees comprised within the quality management system, the accountability structure, charter requirements, and describes the work plan used by each of the QIC Subcommittees to track the progress of performance measure indicators (PMI) and quality improvement initiatives (QII).<br><br>The description of the DBHDS QMS also continues to specify responsibilities | 22nd - Met*<br><br>**23rd - Met** |

| Compliance Indicator | Facts | Analysis | Conclusion |
|---|---|---|---|
| and implement the improvement strategies as needed.<br>f. Identify areas of success to be expanded or replicated; g. Document reviewed information and corresponding decisions about whether an improvement strategy is needed.<br>The DBHDS Quality Management System is comprised of the following functions: a. Quality Assurance, b. Quality Improvement, and c. Risk Management | implementation of a full quality cycle.<br><br>For the 23rd Period, and as described throughout this study, despite some remaining needs for enhancements, DBHDS efforts overall sufficiently demonstrated they met the requirements for data validity and reliability that are a pre-requisite to a functional quality management system. DBHDS consistently submitted more complete Process Documents and Data Set Attestations to evidence this. | and policies and procedures for implementation of a quality cycle, as specified in a-f of the Compliance Indicator, including the use of the well-recognized Plan-Do-Study-Act (PDSA) quality improvement model as a guide for implementing the quality cycle. The charters for the QIC and its subcommittees again defined an expectation that each subcommittee will be responsive to identified issues using corrective actions, remedies, and quality improvement initiatives (QIIs) as indicated, and that the subcommittees will utilize the PDSA Model for such initiatives. As reported previously, this continued to be well evidenced in the QII documents reviewed for this current study period.<br><br>Previous reports have also stressed that having valid and reliable data was a crucial pre-requisite to a functional QMS and have frequently documented deficiencies in this area. As described in previous reports, on 1/21/22, the Parties jointly filed with the Court an agreed-upon *Curative Action for Data Validity and Reliability*. It stated that DBHDS would continue to review data sources and update the quality management plan annually as required, including recommendations around actionable items for the systems to increase their quality and a deep dive into each source system every 3-5 years to test and follow the data and to review and identify source system threats to data reliability and validity. At the time of the 22nd Period Review, the plan described the Office of Epidemiology and Health Analytics (EHA), formerly the Office of Data Quality and Visualization (DQV) as having these responsibilities, including the development of a comprehensive *Data Quality Monitoring Plan* (*DQMP*). Based on interviews with DBHDS staff for the 22nd Period review, while the EHA office no longer existed, its functions would remain but be dispersed in other parts of the organizational structure. At time of the 22nd Period study, DBHDS had not yet developed any documentation that clearly described this realignment of staff and function, but in interview indicated a plan to do so.<br><br>For this 23rd Period, the *Curative Action for Data Validity and Reliability* remained in effect. In addition, the *DQMP*, dated 9/28/23, documented that following the dissolution of the Office EHA in January 2023, the Office Clinical Quality Management (OCQM) personnel and OCQM independent data system analyst consultants assumed the role of assessor for the annual review data sources and update of the quality management plan. Additional details may be found with | |

| Compliance Indicator | Facts | Analysis | Conclusion |
|---|---|---|---|
| | | regard to CI 36.1 and CI 38.1.<br><br>The 22nd Period study found that DBHDS had made continued strides in this area, but some challenges persisted. In particular, while Process Documents more often documented the previously identified (i.e., by EHA) threats to data validity and reliability, they only inconsistently identified clear mitigation steps that would ameliorate the threats. In addition, the *Curative Action for Data Validity and Reliability* required that for each Process Document, the DBHDS the Chief Data Officer (CDO) would assert data set quality by signing off on a Data Set Attestation Form for use of the applicable data set. Although DBHDS consistently provided these documents, they often did not attest to the sufficiency of the Process Document mitigation steps for addressing threats to reliability and validity based on deficiencies that potentially emanated from data entry concerns.<br><br>For the 23rd Period, and as described throughout this study, DBHDS consistently submitted more complete Process Documents and Data Set Attestations. Despite some remaining needs for enhancements, overall, DBHDS efforts sufficiently demonstrated they met the requirements for data validity and reliability. CI 36.1 provides additional details on this topic. | |
| **29.2**<br>The Offices of Licensing and Human Rights perform quality assurance functions of the Department by determining the extent to which regulatory requirements are met and taking action to remedy specific problems or concerns that arise. | There have been no structural or functional changes in the Office of Licensing (OL) or the Office of Human Rights (OHR) since the 22nd study. OL and OHR have continued to fulfill their defined quality assurance functions to assess the extent to which providers are meeting regulatory requirements. Their review processes include specific methods to address areas | There have been no structural or functional changes in the Office of Licensing (OL) or the Office of Human Rights (OHR) since the 22nd study. OL revised the *Annual Compliance Determination Chart* for 2023 including expanded and refined guidance and instructions for licensing specialists to determine whether providers are meeting regulatory requirements. This chart continues to serve as a comprehensive reference tool to increase consistent analysis of provider compliance for each licensing regulation.<br><br>OL has continued to develop and deliver training for providers and licensing specialists relevant to the Licensing Regulations, inspection protocols, and specific areas of challenge faced by providers in meeting regulatory requirements with focused attention on requirements at *12VAC35-105-160, 520, and 620*. Regional Managers and Quality Improvement Review Specialists conduct look-behind | 22nd - Met<br><br>**23rd - Met** |

| Compliance Indicator | Facts | Analysis | Conclusion |
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| | where providers are not meeting regulatory requirements.<br><br>The *Annual Compliance Determination Chart* is updated annually by OL and serves as a comprehensive reference tool for licensing specialists to increase consistent analysis of provider compliance for each licensing regulation.<br><br>OL continues to develop and deliver training for providers and licensing specialists relevant to licensing regulation requirements and methods by which these requirements are assessed. The licensing requirements at 12VAC35-105-160, 520, and 620 have been given considerable focus in 2023.<br><br>From a review of a sample of 41 RCAs completed by 22 licensed providers, the Consultant determined that the quality of the RCAs continue to improve and that licensing specialists continue to consistently adhere to the requirements for assessment of compliance with regulatory | quality assurance reviews of sampled licensing inspections to verify the accuracy and consistency of licensing specialist inspections and resulting CAP reports and to identify specific areas where licensing specialists and providers may need additional training.<br><br>During the 20th study, the determination of "Not Met" for this Compliance Indicator centered on the Consultant's noted significant disagreement with licensing specialist determinations of whether providers were meeting regulatory requirements at *12VAC35-105-160.E.1.a-c* relating to root cause analysis investigations (RCAs). The Consultant's comparative analysis of a sample of RCAs during the 22nd study noted improvements in the quality of the RCAs in the sample review and a higher percentage of agreement between the determinations of the licensing specialist as to whether the RCAs included requirements at §160.E.1.a-c. For the 23rd period study, the Consultant conducted a similar review of 41 RCAs completed by 22 of the 25 sample providers (three providers in the sample did not have any RCAs completed during the annual licensing review period). The RCAs reviewed in this sample were improved over those reviewed in the previous two samples (20th and 22nd studies). The consultant's agreement with licensing specialist determinations ranged from 17/22 to 19/22 for the three regulatory requirements in this section. While there were some differences between the Consultant's and the licensing specialists' determinations of whether providers met the requirements, recognizing the small sample size and the awareness that there may not have been 100% consistency in the RCAs reviewed during the annual inspection and those reviewed in the sample, the variances do not appear significant. The Consultant determined that the sample results support that licensing specialists continue to consistently follow the requirements to determine if regulations are met based on guidance and instructions in the *2023 Annual Compliance Determination Chart* . The details of the sample review analysis and results relevant to meeting requirements at *160.E.1.a-c* are described in the Analysis section at Compliance Indicator 29.4 below. | |

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| | requirements at §160.E.1.a-c that describe the requirements for RCA content. | | |
| **29.4**<br>ii. The provider has conducted at least quarterly review of all Level I serious incidents, and a root cause analysis of all level II and level III serious incidents; iii. The root cause analysis, when required by the Licensing Regulations, includes i) a detailed description of what happened; ii) an analysis of why it happened, including identification of all identifiable underlying causes of the incident that were under the control of the provider; and iii) identified solutions to mitigate its reoccurrence. | There have been no significant changes made in the process utilized by licensing specialists to determine if a provider is meeting the requirements at §160.C since completion of the 22nd study.<br><br>Data regarding the 819 annual licensing inspections completed during the first six months of CY 2023 support that licensing specialists continue to consistently assess whether providers are meeting the requirements at §160.C following guidance and instructions in the 2023 Annual Compliance Determination Chart.<br><br>Results from the Consultant's sample review of documentation from 25 licensed providers relevant to the requirements at §160.C supported the determination that licensing specialists are consistently assessing provider compliance with the requirements at §160.C | *12VAC35-105-160.C* establishes the requirement that providers collect, maintain, and review at least quarterly all serious incidents, including Level I serious incidents as a part of their quality improvement program. This process must include an analysis of trends, potential systemic issues or causes, indicated remediation, and documentation of steps to mitigate the potential for future incidents.<br><br>The specific instructions for licensing specialists to determine whether a provider meets these requirements are described in the *2023 Annual Compliance Determination Chart*.<br><br>Specific to the assessment of whether providers are meeting the requirements for this regulation based on data provided in the *29.4 Sample 160.E and 160.C Data Report:*<br>• Of the 838 licensed providers inspected since 01/01/2023 for which a determination could be made (19 were non-determined), 662/819 (80.8%) met the requirements at *160.C*.<br>• A sample of 25 providers was selected to assess whether the Consultant's determination of whether the provider is meeting the requirements at §160.C agreed with that of the licensing specialist. Within the sample, licensing specialists determined that 14/25 (56.0%) met the requirements. The Consultant's sample review noted that 12/25 (48%) providers met the requirements at *160.C*.<br>• While the results of the sample are significantly different when compared to the results of all 819 providers that were inspected between 01/01/2023-06/30/2023, the consistency in the comparison between the findings of the licensing specialist and those of the Consultant for the 25 sample providers supports the determination that licensing specialists are consistently following the guidance and instructions in the *2023 Annual Compliance Determination Chart* when determining whether the provider is meeting these regulatory | 22nd - Met<br><br>**23rd - Met** |

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| | following guidance and instructions in the 2023 Annual Compliance Determination Chart.<br><br>OL continues to develop tools and example formats to assist provider's in conducting and documenting RCAs and related risk analysis processes. | requirements.<br><br>The Consultant's 22nd study sample review focused on improvement in the quality of RCA reports and the increased agreement between the Consultant's and licensing specialists' determinations specific to *160.E.1.a-c*. The current study included a similar sample review and analysis of 41 RCAs completed by 22 of 25 sample providers (three had no RCAs completed during the annual licensing review period). The following determinations were made based on this sample review:<br><br>• **E.1.a:**<br>  • Of the 719 licensed providers inspected between 01/01/2023-06/30/2023 for which a determination could be made (124 did not have RCAs), licensing specialists determined that 631/719 (87.8%) met the requirements.<br>  • Within the sample of 22 providers who had RCAs, licensing specialists determined that 20/22 (90.9%) met the requirements. The Consultant's sample review did not result in a significantly different outcome with 19/22 (86.4%) meeting the requirements.<br>• **E.1.b:**<br>  • Of the 719 licensed providers inspected between 01/01/2023-06/30/2023 for which a determination could be made (124 did not have RCAs), licensing specialists determined that 628/719 (87.3%) met the requirements.<br>  • Within the sample of 22 providers who had RCAs, licensing specialists determined that 20/22 (90.9%) met the requirements. The Consultant's sample review was slightly lower with 18/22 (81.8%) meeting the requirements.<br>• **E.1.c:**<br>  • Of the 719 licensed providers inspected between 01/01/2023-06/30/2023 for which a determination could be made (124 did not have RCAs), 627/719 (87.2%) met the requirements.<br>  • Within the sample of 22 providers who had RCAs, licensing specialists determined that 20/22 (90.9%) met the requirements. The Consultant's sample review was somewhat below that level with only 17/22 (77.3%) meeting the requirements. | |

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| | | There was some variation in the sample review percentages when comparing the licensing specialist findings with those of the Consultant; however, given the small sample size and the awareness that there may not have been 100% consistency in the RCAs reviewed during the annual inspection and those reviewed in the sample, the results of the sample are sufficient to support that licensing specialists are consistently following the guidance and instructions in the *2023 Annual Compliance Determination Chart* when determining whether the provider is meeting regulatory requirements.<br><br>The OL continues to improve consistent assessment of providers meeting regulatory requirements through revised protocols, increased look-behind reviews, and additional training for licensing specialists focusing on improved accuracy and thoroughness of their regulatory determinations, particularly for regulations at §160.C and §160.E.1.a-c. Some examples of helpful tools that have been developed and shared with providers in recent months include a *Serious Incident Review and Root Cause Analysis Template (April 2023)* , an *Individual Risk Tracking Tool (April 2023)*, and a *Monthly Risk Tracking Tool*, suggesting their use to assist providers with these processes. OL has also developed an *Instructional Video-Risk Tracking Tool (April 2023)* to provide guidance for using these tools. Providers were reminded of these tools in a memorandum to providers dated 10/05/2023, *29.16 IMU Look Behind Provider Notification 10.3.2023*, noting the purpose and process descriptions for the IMU Look-Behind Process completed by Virginia Commonwealth University (VCU).<br><br>Based on results from the sample reviews described above and the data reports and analyses provided by the OL, there is sufficient evidence to conclude that OL is continuing to refine and improve its processes to assess provider compliance with the serious incident reporting requirements of the Licensing Regulations as part of the annual inspection process. | |

| Compliance Indicator | Facts | Analysis | Conclusion |
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| **29.8**<br>The Office of Clinical Quality Improvement oversees and directs contractors who perform quality review processes for DBHDS including the Quality Services Reviews and National Core Indicators. Data collected from these processes are used to evaluate the sufficiency, accessibility, and quality of services at an individual, service, and systemic level. | Overall, DBHDS fulfilled the requirements of this Indicator.<br><br>*Departmental Instruction 316 (QM) 20 Quality Improvement, Quality Assurance and Risk Management for Individuals with Developmental Disabilities* and the *Developmental Disabilities Quality Management Plan State Fiscal Year 2024* identify the OCQM as the responsible entity to oversee and direct contractors who perform quality review processes for DBHDS including the Quality Services Reviews (QSR) and National Core Indicators (NCI.)<br><br>DBHDS also previously provided additional OCQM policy and procedure to operationalize these responsibilities, including *the Quality Service Reviews (QSRs) and National Core Indicators (NCI) Policy & Procedur*e and *National Core Indicators (NCI) Practices*, both last revised on 2/1/23.<br><br>According to the *Developmental Disabilities Quality Management Plan State Fiscal Year 2024,* DBHDS utilizes a contracted vendor to conduct Quality | As reported at the time of 22nd Period, the *Departmental Instruction 316 (QM) 20 Quality Improvement, Quality Assurance and Risk Management for Individuals with Developmental Disabilities* remains in effect. It identifies the OCQM as the responsible entity to oversees and directs contractors who perform quality review processes for DBHDS including the National Core Indicators (NCI) and the Quality Services Reviews (QSR). For the 22nd Period review, DBHDS also provided additional OCQM policy and procedure to operationalize these responsibilities, including a *Quality Service Reviews(QSRs) and National Core Indicators (NCI) Policy & Procedur*e and a *National Core Indicators (NCI) Practices*, both last revised on 2/1/23. According to the *Developmental Disabilities Quality Management Plan State Fiscal Year 2024*, DBHDS utilizes a contracted vendor to conduct Quality Service Reviews (QSR) and contracts with Virginia Commonwealth University (VCU),The Partnership for People with Disabilities (Partnership) to conduct the surveys required for the NCI project.<br><br>Based on the *Developmental Disabilities Quality Management Plan State Fiscal Year 2024*, "QSRs are completed on a sample of individuals receiving services … to gain information about the quality of services provided and to obtain individual, staff and family input on services provided to identify opportunities for improvements in the service experience and to determine how to improve the array of services provide … QSRs also provide an assessment of whether individuals' needs are being identified and met through person-centered planning and thinking, 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 given opportunities for community integration in all aspects of their live … Additionally, QSRs assess the quality and adequacy of providers' services, QI and RM strategies and provide recommendations to providers for improvement. Results of the QSRs are used to improve individual provider and system practice and service quality."<br><br>With regard to the use of QSR data, for the 23rd Period review, the QIC, subcommittees and workgroups continued to review QSR data and recommendations. The QIC Review Schedules for FY 24 included a QSR report for each of the quarterly agendas. DBHDS indicated it continues to use QSR data as the basis for measuring performance with several PMIs and DOJ | 22nd – Met*<br><br>**23rd - Met** |

| Compliance Indicator | Facts | Analysis | Conclusion |
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| | Service Reviews (QSR) and contracts with Virginia Commonwealth University (VCU),The Partnership for People with Disabilities (Partnership) to conduct the surveys required for the NCI project. DBHDS uses the data from both the QSRs and NCI to identify opportunities for quality improvement.<br><br>DBHDS designed the QSR to produce data to evaluate the sufficiency, accessibility, and quality of services at an individual, service, and systemic level. DBHDS indicated it continues to use QSR data as the basis for measuring performance with several PMIs and DOJ CIs.<br><br>The QIC Review Schedules for FY 24 included a QSR report for each of the quarterly agendas. Meeting minutes showed that the QIC and the QIC's subcommittee and workgroup meeting minutes regularly reviewed and analyzed QSR findings, and responded to QSR recommendations. | CIs, as well as one QII.<br><br>While concerns remained with regard to QSR data validity and reliability, as described below for CI 36.1, the Process Documents and Data Set Attestations for CIs with QSR data provided for this 23rd Period at least minimally met the requirements described in *Curative Action for Data Validity and Reliability*.<br><br>For the 23rd Period review, with regard to NCI, DBHDS provided meeting agendas and minutes that demonstrated OCQM continued to meet monthly between October 2022 through June 2023 with the VCU to coordinate and oversee activities. VCU also provided written reports of activities each month from November 2022 through June 2023.<br><br>The QIC and its subcommittees and workgroups continued to review NCI data and recommendations. The QIC Review Schedules for FY 24 included annual NCI reporting for the fourth quarterly agenda. DBHDS indicated it continues to use NCI data as the basis for measuring performance for compliance with CI 29.27 (i.e., at least 75% of people with a job in the community chose or had some input in choosing their job).<br><br>As reported previously, the NCI survey process is entirely external to DBHDS and has a lengthy track record of consistent implementation and documentation of data provenance. NCI measures have also been approved by CMS for use in HCBS waiver programs. As such, NCI data could be considered reliable for use in evaluating the sufficiency, accessibility, and quality of services at an individual, service, and systemic level.<br><br>For this 23rd Period DBHDS provided a set of documents that further supported the validity and reliability of the data (e.g., NCI Consumer Survey psychometrics Description, a link to the National Quality Forum (NQF) NCI endorsed measures, NQF Evidence attachments for National Core Indicators for Intellectual and Developmental Disabilities (ID/DD) Home and Community-Based Services Measures, etc.). In addition, for the previous review period, DBHDS provided a Data Set Attestation Form for the NCI Data Set and the | |

| Compliance Indicator | Facts | Analysis | Conclusion |
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| | DBHDS indicated it continues to use QSR data as the basis for measuring performance with several PMIs and DOJ CIs, as well as one QII.<br><br>While concerns remained with regard to QSR data validity and reliability, as described below for CI 36.1, the Process Documents and Data Set Attestations for CIs with QSR data provided for this 23rd Period at least minimally met the requirements described in *Curative Action for Data Validity and Reliability*.<br><br>Data from the NCI are also used to evaluate the sufficiency, accessibility, and quality of services at a systemic level. Meeting agendas and minutes demonstrated OCQM continued to meet monthly between October 2022 through June 2023 with the VCU to coordinate and oversee activities. VCU also provided written reports of activities each month from November 2022 through June 2023.<br><br>DBHDS indicated it continues | NCI Adult Consumer Survey that is still applicable for this 22nd Period. | |

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| | to use NCI data as the basis for measuring performance for compliance with CI 29.27 (i.e., at least 75% of people with a job in the community chose or had some input in choosing their job).<br><br>As reported previously, the NCI survey process is entirely external to DBHDS and has a lengthy track record of consistent implementation and documentation of data provenance. NCI measures have also been approved by CMS for use in HCBS waiver programs. As such, NCI data could be considered reliable for use in evaluating the sufficiency, accessibility, and quality of services at an individual, service, and systemic level. In addition, for the previous review period, DBHDS provided a *Data Set Attestation Form for the NCI Data Set and the NCI Adult Consumer Survey* that is still applicable for this 22nd Period. | | |

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| **29.10**<br>The QIC sub-committees report to the QIC and 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. The QIC sub-committees evaluate data at least quarterly, identify at least one CQI project annually, and report to the QIC at least three times per year. | Overall, DBHDS fulfilled the activities required by this Indicator.<br><br>The QIC sub-committees reported to the QIC four times in the period between 12/12/22 through 9/20/23.<br><br>Each subcommittee has adopted performance measures and Quality Improvement Initiatives (QIIs) that focus on identifying and addressing risks of harm and ensuring the sufficiency, accessibility, and quality of services to meet individuals' needs in integrated settings.<br><br>The QIC subcommittees each identified at least one CQI project annually.<br><br>For this 23rd period review, the study found that QIIs were generally measurable, included baselines and provided a clear definition of terms.<br><br>For this 23rd Period review, DBHDS staff consistently presented data and/or narrative information on the status of action steps and on | At the time of the 22nd Period review, DBHDS had fulfilled the activities required by this Indicator overall, with adequate procedures in place that would support the ability to do this work. However, questions remained about the adequacy of some of the Process Documents and accompanying Data Set Attestations relied upon for some QIIs (e.g., Process Document for *Serious Incident Reports by Type - Surveillance Rates*).<br><br>For this 23rd Period, based on documentation provided, the QIC sub-committees have made reports to the QIC four times in the past twelve months (i.e., on 12/12/22, 3/27/23, 6/26/23 and 9/20/23). The subcommittee reports continue to focus on the respective performance measures and QIIs each has adopted, based on data each QI reviews and that 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.<br><br>Each of the subcommittees had adopted at least one QII. The 21 current QIIs were a mix of projects continued from previous FY periods and new projects identified for FY24. The following describes the status and progress DBHDS staff achieved with regard to previously identified deficiencies:<br>• For this 23rd period review, the study found that QIIs were generally measurable, included baselines and provided a clear definition of terms.<br>• For this 23rd Period review, DBHDS again staff consistently presented data and/or narrative information on the status of action steps and on outcomes.<br>• At the time of the 22nd Period review, to ensure a verified reliable and valid data sources for all QIIs, DBHDS staff had made a consistent effort to identify and track the data sets they use for QII projects. For this 23rd Period, as indicated in the documents *SFY24 QII Dataset Process and Attestation Tracker*, DBHDS staff had identified a Process Document and a Data Set Attestation for all 21of the current QIIs.<br>• One of the current QIIs relied upon serious incident data, which had been identified as a deficiency during the 23rd Period review. As described with regard to CI 29.13 below, for this 23rd Period review, | 22nd - Met*<br><br>**23rd - Met** |

| Compliance Indicator | Facts | Analysis | Conclusion |
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| | outcomes.<br><br>For this 23rd Period, as indicated in the documents *SFY24 QII Dataset Process and Attestation Tracker*, DBHDS staff had identified a Process Document and a Data Set Attestation for all 21of the current QIIs.<br><br>One of the current QIIs relied upon serious incident data, which had been identified as a deficiency during the 23rd Period review. As described with regard to CI 29.13, for this 23rd Period review, DBHDS provided documentation to show that the applicable Process Document and Data Set Attestation were sufficient for ensuring the validity and reliability of the data. | DBHDS provided documentation to show that the applicable Process Document and Data Set Attestation were sufficient for ensuring the validity and reliability of the data.<br><br>Overall, DBHDS fulfilled the activities required by this Indicator. | |
| **29.13**<br>The RMRC reviews and identifies trends from aggregated incident data and any other relevant data identified by the RMRC, including allegations and substantiations of abuse, | This CI was not met because the RMRC did not review data and identify trends from allegations and substantiations of abuse, neglect, and exploitation, at least four times per year. The RMRC minutes for the past year included only two presentations of ANE | The 22nd Period review described the written processes that laid out an adequate framework for completing these responsibilities. These included the *RMRC Charter*, which required that the RMRC review data for serious incidents and allegations and substantiations of abuse, neglect, and exploitation at least four times per year; the *RMRC Task Calendar and Charter Tasks* which are the scheduling tool used by the RMRC to ensure that it conducts reviews and analysis of surveillance data specific to abuse/neglect, exploitation, Office of Human Rights look-behind results, serious incidents, the IMU look-behind (triage) process, incident management care concerns, timeliness of reporting and | 22nd - Not Met<br><br>**23rd - Not Met** |

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| neglect, and exploitation, at least four times per year by various levels such as by region, by CSB, by provider locations, by individual, or by levels and types of incidents. | data, which occurred in February 2023 and June 2023.<br><br>Otherwise, in the months between April 2023 through September 2023, the RMRC met monthly and reviewed/analyzed data and information on performance measures, quality improvement initiatives and certain other data sources.<br><br>In addition to the February review of serious incident data reported at the time of the 22nd Period review, the RMRC meeting minutes evidenced that the RMRC reviewed some type of aggregate data related to serious incidents (i.e., either the IMU Data Review or the Serious Incident Data Review) on three other occasions during calendar year 2023, for a total of four. However, these presentations did not address allegations and substantiations of abuse, neglect, and exploitation (ANE).<br><br>For 23rd Period review, DBHDS submitted sufficient factual evidence to show it | related citations, relevant state facilities data, and performance measures; and, the *RMRC QIC Subcommittee Work Plan,* which is the comprehensive tracking and information tool used by the RMRC to document their review and analysis activities, including the activities undertaken, data and information reviewed/analyzed, and follow-up activities resulting from the analysis of data and information. For the 23rd Period, these tools and processes continued to be in place.<br><br>At the time of the 22nd Period review, RMRC meeting minutes for meetings held from January 2022 through March 2023 provided evidence that the committee reviewed and analyzed various data in an effort to identify trends in each of their monthly meetings, but this did not review serious incident data, including allegations and substantiations of abuse, neglect, and exploitation, at least four times per year by various levels, due to unresolved data validity and reliable issues. The single review of serious incident data took place at the February RMRC meeting held on 2/27/23.<br><br>For this 23rd Period review, in addition to the February review of serious incident data, RMRC meeting minutes for April 2023 through September 2023 evidenced that the RMRC reviewed some type of aggregate data related to serious incidents (i.e., either the *IMU Data Review* or the *Serious Incident Data Review*) on three other occasions during calendar year 2023:<br>• In May 2023, the RMRC reviewed presentations for both *IMU Data Review* and *Serious Incident Data Review.*<br>• In July, 2023 the RMRC meeting included a *Serious Incident Data Review* presentation.<br>• In August, 2023 the RMRC reviewed a presentations for the *IMU Data Review*.<br><br>However, the presentations described above did not always address allegations and substantiations of abuse, neglect, and exploitation (ANE). The RMRC minutes reviewed from August 2022 through September 2023 included only two presentations of ANE data, which occurred in February 2023 and June 2023. In interview, DBHDS staff noted that, in June 2023, the RMRC reviewed a full | |

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| | addressed all previously identified specific threats to the reliability and validity of data derived from the CHRIS and CONNECT data source systems, as well as specific steps to achieve needed remediation, including but not limited to those found in the DBHDS *RMRC Data Reporting Roadmap: A Path to Improved Data Quality in Routine Data Reporting* (*Roadmap*), dated 2/4/22. The documentation included, but was not limited to *CONNECT Actionable Recommendations* documents, completed pursuant to the *DQMP* annual evaluation of data sources described in CI 36.1, a *RMRC Roadmap Progress V4*, numerous planning and technical specification documents, a revised Process Document entitled *SIR by Type Surveillance Rates ANE VER004,* dated 8/22/2023, a Data Set Attestation for the Process Document and the related data reports, and a Process Document entitled *HR Process Document Free From ANE 29.23, Ver 005*, dated 10/12/23. For the latter, a revision to the current Data Set Attestation, | year of ANE data, rather than a quarter. While it was positive the committee completed this retrospective review, this approach would not allow DBHDS to take timely corrective actions and does not meet the requirements for the frequency of review.<br><br>To achieve compliance DBHDS should ensure that the RMRC quarterly presentations always address allegations and substantiations of abuse, neglect, and exploitation and that the data reviewed are from the most recent quarter to allow timely corrective actions by DBHDS.<br><br>Previous reports have documented that DBHDS could not attest the data were valid and reliable. During the 21st Period review, DBHDS provided a document developed by the RMRC's Data Workgroup, entitled *RMRC Data Reporting Roadmap: A Path to Improved Data Quality in Routine Data Reporting* (*Roadmap*), dated 2/4/22, that spelled out a series of specific threats to the reliability and validity of data derived from the CHRIS and CONNECT data source systems, as well as specific steps to achieve needed remediation. At the time of the 22nd Period review, DBHDS submitted a Process Document entitled *Serious Incident Reports by Type Surveillance Rates* and a Data Set Attestation for the RMRC SIR Data set that provided minimal evidence of the actual completion of the specific steps outlined in the aforementioned *Roadmap* document other than to provide written statements that the steps were complete. At that time DBHDS attested they had completed the required steps, but provided minimal factual evidence. This was insufficient to demonstrate compliance. The 22nd Period study therefore found that for CI 29.13, as well as other indicators that rely on reporting of serious incident data, DBHDS needed to provide sufficient factual evidence to show it addressed all previously identified specific threats to the reliability and validity of data derived from the CHRIS and CONNECT data source systems, as well as specific steps to achieve needed remediation, including but not limited to those found in the DBHDS *Roadmap.*<br><br>It was positive, then, that for the 23rd Period review, DBHDS staff provided numerous documents to demonstrate the efforts made to ensure the serious incident data were valid and reliable and could be used for compliance reporting. | |

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| | dated 8/30/23, is pending for the most recent revisions, but does not substantially impact compliance for the purpose of this CI. | In summary, these included:<br>• *RMRC Roadmap Progress V4*, updated 8/18/23.<br>• *CONNECT Actionable Recommendations*, dated 7/18/23, completed pursuant to the *DQMP* annual evaluation of data sources described in CI 36.1.<br>• *CONNECT Actionable Recommendations Final -Detailed Response*, dated 7/18/23, which provided a detailed analysis and response from OL and the DBHDS IT department.<br>• *CONNECT AR Actionable Recommendations - Actions and Timeline*s, undated, which included a summary table of the recommendations and actions DBHDS planned to take in the near future, with numerous attachments outlining related processes.<br>• Planning documents, outlining the project tasks to be accomplished and describing the overall processes for completing them (e.g., *CONNECT O&M Plan*, approved 5/4/22, *Goal and Scope Service to Diagnosis Project*, dated 5/23/23, and a searchable *GL Solutions Final Contract*, dated 11/16/18, etc.).<br>• Numerous technical specification documents (e.g., *Data Conversion Crosswalk OLIS to CONNECT* dated 7/3/23, *CHRIS Export Interface Specification* dated 7/13/23, *CHRIS Import Interface Specification*, dated 7/11/23, *CONNECT-CHRIS Data Transfer*, dated 6/9/23, *DW Connect Service Program Data*, dated 7/11/23, *Service Program Code Data*, dated 6/27/23, etc.).<br>• A Process Document entitled *SIR by Type Surveillance Rates ANE VER004*, dated 8/22/2023.<br>• A Data Set Attestation for the Process Document and the related data reports (i.e., *DW-0123-CHRIS Incident Report*, *DW-003a-OHR_CONNECT CSB Incidents*, *DW-0038a-OHR_Connect Provider Incidents)*, dated 8/29/23.<br><br>These documents were sufficient to demonstrate DBHDS met the data validity and reliability requirements for this Period.<br><br>With regard to ANE data validity and reliability, DBHDS submitted a Process Document (i.e., *HR Process Document Free From ANE 29.23, Ver 005*, dated | |

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| | | 10/12/2023) and Data Set Attestation, dated 8/30/23 for this Period. A revision to the current Data Set Attestation, dated 8/30/23, is pending for the most recent revisions, but does not substantially impact compliance for the purpose of this CI. As described with regard to CI 29.23, these documents are sufficient to demonstrate DBHDS met the data validity and reliability requirements for this Period.<br><br>Going forward, DBHDS should revise the materials as needed to reflect new information. Of note, as part of the *DQMP* annual evaluation, in August 2023, OCQM completed assessments of CHRIS-SIR and CHRIS-OHR and identified data threats not addressed in the previous source system assessments. Future versions of the related Process Document and Data Set Attestations should incorporate these findings. | |
| **29.14**<br>The RMRC uses the results of data reviewed to identify areas for improvement and monitor trends. The RMRC identifies priorities and determines quality improvement initiatives as needed, including identified strategies and metrics to monitor success, or refers these areas to the QIC for consideration for targeted quality improvement efforts. The RMRC ensures that each approved quality improvement initiative is | Overall, DBHDS fulfilled the requirements for this CI.<br><br>For this 23rd Period, the *SFY 23 RMRC QIC Subcommittee Work Plan*, *SFY24 RMRC QIC Subcommittee Work Plan* and RMRC meeting minutes demonstrated that the RMRC continued to review and analyze data, monitor apparent trends and patterns in certain data, and identify areas of improvement that appeared to be warranted from their review and analysis of data and trends to the extent possible.<br><br>The RMRC identifies | For this 23rd Period review, the *SFY 23 RMRC QIC Subcommittee Work Plan*, *SFY24 RMRC QIC Subcommittee Work Plan* and RMRC meeting minutes demonstrated that the RMRC continued to review and analyze data, monitor apparent trends and patterns in certain data, and identify areas of improvement that appeared to be warranted from their review and analysis of data and trends to the extent possible.<br><br>In addition, the RMRC recommended at least one QII per year to the QIC, based on their review and analysis of the available data. At the time of this review, the RMRC was engaged in two QIIs.<br>• One was a continuing joint effort with the Region 5 Regional Quality Council to increase provider compliance with two key risk management licensing regulations (i.e., regulations 520C and 520D ) to 86% by FY23, Q4 (June 30, 2023). For purposes of measuring progress, the RMRC documented baseline percentages for CY 21as follows: For 520C.1: 85%; 520C.2: 81%; 520C.3: 80%; 520C.4" 79%; and 520C.5: 85%; and for 520D: 79%. DBHDS submitted an applicable Process Document entitled *Risk Management Program Compliance Ver 005,* dated 8/23/23 and a Data Set Attestation, dated 8/30/23.<br>• The RMRC recommended an additional QII to the QIC, which was | 22nd - Met*<br><br>**23rd - Met** |

| Compliance Indicator | Facts | Analysis | Conclusion |
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| implemented and reported to the QIC. The RMRC will recommend at least one quality improvement initiative per year. | priorities and determines quality improvement initiatives, including identified strategies and metrics to monitor success.<br><br>The RMRC recommended at least one quality improvement initiative per year. At the time of this review, the RMRC was engaged in two QIIs. One was a continuing joint effort with the Region 5 Regional Quality Council to increase provider compliance with two QI licensing regulations. The second was a new QII to improve the percentage of licensed services that develop and submit an annual report of each instance of seclusion or restraint or by the end of January each year, per human rights regulation *12 VAC 35-115-230 C.2.* to 86% by April 2024.<br><br>As described with regard to 29.13 above, DBHDS met the requirements for demonstrating the incident data they relied upon for much of their work was valid and reliable. For the abuse, neglect and exploitation data the | approved on 6/26/23 and implemented on 8/2/23. The goal of this QII is to improve the percentage of licensed services that develop and submit an annual report of each instance of seclusion or restraint or by the end of January each year, per human rights regulation *12 VAC 35-115-230 C.2.*, to 86% by April 2024. The RMRC reported the baseline as 48% during FY23 (for CY2022). DBHDS submitted an applicable Process Document entitled *OHR Annual Seclusion and Restraint Reporting Form, Ver 002*, dated 8/1/23, and Data Set Attestation dated 9/1/23.<br><br>On 4/24/23, RMRC also abandoned a QII, implemented on 7/1/21, to reduce the number serious incidents caused by falls. While they had implemented several strategies during this span of time, the serious incident data limitations described above for CI 29.13 had effectively prevented the RMRC from reviewing or identifying relevant trends. When data became available, it showed that while the PDSAs and tests of change were successful independently, they did not serve to achieve a sustained 10% reduction in the rate of fall SIRs. The RMRC elected to end this QII, continue to monitor the trend, and possibly consider another QII focused on falls in the future. In interview, DBHDS staff provided an overview of the additional examination the RMRC planned to undertake. Overall, this was a good example of the implementation of the quality improvement cycle.<br><br>As described with regard to 29.13 above, DBHDS met the requirements for demonstrating the incident data they relied upon for much of their work was valid and reliable. For the abuse, neglect and exploitation data the RMRC uses, DBHDS submitted a Process Document and Attestation, as described with regard to CI 29.23. These also met the requirements to demonstrate data validity and reliability. | |

| Compliance Indicator | Facts | Analysis | Conclusion |
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| | RMRC uses, DBHDS submitted a Process Document and Attestation, as described with regard to CI 29.23. These also met the requirements to demonstrate data validity and reliability. | | |
| **29.16**<br>The RMRC conducts or oversees a look behind review of a statistically valid, random sample of DBHDS serious incident reviews and follow-up process. The review will evaluate whether: i. The incident was triaged by the Office of Licensing incident management team appropriately according to developed protocols.<br>ii. The provider's documented response ensured the recipient's safety and well-being.<br>iii. Appropriate follow-up from the Office of Licensing incident | DBHDS implemented a look-behind review of a statistically valid, random sample of serious incident reviews and follow-up processes conducted by VCU in 2022. Initially, the reviews addressed only three of the four required outcomes specified in this Compliance Indicator. Outcome 4 information was added during the Q1 2023 review period, however there were issues with information availability through the CONNECT system so the outcome could not be accurately assessed.<br><br>To date, VCU has completed three rounds of these reviews and presented the results to the RMRC for review and | The DBHDS process for look-behind review of a statistically valid, random sample of serious incident reviews and follow-up processes conducted by the Virginia Commonwealth University (VCU) was described in detail in the 22nd study report. That study report confirmed that a documented process that meets the requirements at Outcomes 1-3 (29.16.i, 29.16.ii, and 29.16.iii) was implemented and it provided data from the Q2 2022 and Q3 2022 analysis reports completed by VCU for the Risk Management Review Committee (RMRC). The 22nd study report also noted that the process to address requirements at Outcome 4 (29.16.iv) had not yet been fully implemented and no data had been collected relevant to this outcome. The RMRC met the requirements at 29.16.v through their review of VCU quarterly reports for Q2 2022 and Q3 2022 and developed and documented follow-up actions in response to the findings from those two reports.<br><br>DBHDS has continued the processes outlined in the 22nd study report. DBHDS did not complete the Q4 2022 look-behind review to allow resolution of issues related to VCU access to documentation in the CONNECT system. DBHDS resumed the process for Q1 2023. The RMRC reviewed the Q1 2023 report (*29.16 IMU Look Behind VCU Findings Report Q1 2023 RMRC 9.11.2023*) in its RMRC meeting on 09/11/2023 (*09/11/2023 RMRC Meeting Minutes*). Results from the three VCU reports completed to date are summarized in the table below: | 22nd - Not Met<br><br>**23rd - Not Met** |

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<tr><th>Compliance Indicator</th><th>Facts</th><th>Analysis</th><th>Conclusion</th></tr>
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<td>management team occurred when necessary.<br>iv. Timely, appropriate corrective action plans are implemented by the provider when indicated.<br>v. The RMRC will review trends at least quarterly, recommend quality improvement initiatives when necessary, and track implementation of initiatives approved for implementation.</td>
<td>analysis. Information related to the quarterly RMRC reviews is documented in RMRC meeting minutes along with recommended follow-up actions. The follow-up actions determined in response to the findings from the Q2 and Q3 2022 reviews have resulted in notable improvement in the scores for Outcomes 1, 2, and 3 since the initial review in Q2 2022.<br><br>While incorporated into the Q1 2023 review process, VCU has not yet been able to sufficiently evaluate Outcome 4 related to timely, appropriate corrective actions plans implemented by the provider when indicated due to issues with access to records in the CONNECT system. These issues are reported to have been resolved to enable a full review in Q2 2023.<br><br>For this 23rd Period, the Commonwealth has not met the requirement of this CI because the RMRC has not fully assessed Outcome 4 (i.e., timely, appropriate corrective</td>
<td>
<table>
<tr><th></th><th>Q2 2022</th><th>Q3 2022</th><th>Q1 2023</th></tr>
<tr><td>Outcome 1</td><td>59%</td><td>78%</td><td>100%</td></tr>
<tr><td>Outcome 2</td><td>86%</td><td>77%</td><td>90%</td></tr>
<tr><td>Outcome 3</td><td>73%</td><td>72%</td><td>82%</td></tr>
<tr><td>Outcome 4</td><td>Not Assessed</td><td>Not Assessed</td><td>Not Assessed</td></tr>
<tr><td colspan="4">Note: Cells highlighted in red did not meet the threshold requirement</td></tr>
</table>
<br>Follow-up address of areas of concern noted in these VCU reports was described in RMRC meeting minutes (29.16 RMRC Minutes 5.22.2023 Approved and 29.16 RMRC Minutes 9.11.2023 draft) and the results of the Q1 2023 VCU report demonstrate the success of these actions as percentages for Outcomes 1, 2, and 3 showed improvement since the initial report for Q2 2022.<br><br>Since this consultant completed the 22nd study, VCU has initiated a process for review of Outcome 4 (29.16.iv). There were issues with the first evaluation that was completed in Q1 2023 as the VCU reviewers did not have access to documentation of provider follow-up in the CONNECT system and were unable to determine if that follow-up was sufficient. DBHDS is resolving this issue by providing additional training to VCU reviewers on methods they can use to access information in the CONNECT system and through giving the reviewers opportunity to follow up directly with providers on any questions they may have regarding address of the identified care concern(s). DBHDS anticipates that these corrective actions will support a full review of Outcome 4 in Q2 2023. In 10/2023, OL issued a provider memorandum, 29.16 IMU Look Behind Provider Notification 10.3.2023, that details the purpose of the IMU Look-Behind, the process steps for its completion, and how the results are used to improve incident management processes for all licensed providers. This OL memo also contains specific information about how documents related to the provider's corrective action plans will be accessed and reviewed by VCU and the specific responsibilities that providers have to cooperate with the VCU reviewers should they be contacted for information.
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| Compliance Indicator | Facts | Analysis | Conclusion |
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| | action plans are implemented by the provider when indicated) or reviewed related trends at least quarterly, recommended quality improvement initiatives when necessary, and, tracked implementation of related initiatives approved for implementation | Based on this consultant's review and analysis of information relevant to this Compliance Indicator, while there continue to be issues with address of Outcome 4, there is sufficient evidence to support that the RMRC has developed and implemented a system to conduct and oversee a look-behind review of a statistically valid, random sample of DBHDS serious incident reviews and follow-up processes. The VCU evaluation process has successfully demonstrated thorough analysis of information required for Outcomes 1-3 (29.16.i, 29.16.ii, and 29.16.iii). DBHDS initiated a process for evaluation of requirements at Outcome 4 (29.16.iv) but has not yet been able to fully evaluate whether providers are implementing timely, appropriate corrective action plans when indicated. Evidence supports that the RMRC has also met requirements at 29.16.v through its review of findings from each of the VCU quarterly reports and has developed and followed through on process improvement initiatives to address and resolve areas of identified concern. To date, these efforts have shown positive impact for Outcomes 1-3 (see data in data table above).<br><br>The Commonwealth has not met the requirement of this Compliance Indicator because the RMRC has not fully assessed Outcome 4 (i.e., timely, appropriate corrective action plans are implemented by the provider when indicated) or reviewed related trends at least quarterly, recommended quality improvement initiatives when necessary, and, tracked implementation of related initiatives approved for implementation.<br><br>DBHDS and VCU jointly developed a structured methodology to assess the requirements of Outcome 4 and initiated use of this methodology in Q2 2023. Using data from Q2 2023 forward, the RMRC should, by amassing sufficient reliable and valid data and information, evaluate whether providers are implementing timely, appropriate corrective action plans when indicated and identify relevant trends and focus areas, recommend quality improvement initiatives when necessary, and track implementation of the initiatives that are approved for implementation. | |

| Compliance Indicator | Facts | Analysis | Conclusion |
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| **29.17**<br>The RMRC conducts or oversees a look-behind review of a statistically valid, random sample of reported allegations of abuse, neglect, and exploitation. The review will evaluate whether: comprehensive and non-partial investigations of individual incidents occur within state-prescribed timelines.<br>ii. The person conducting the investigation has been trained to conduct investigations.<br>iii. Timely, appropriate corrective action plans are implemented by the provider when indicated.<br>iv. The RMRC will review trends at least quarterly, recommend quality improvement initiatives when necessary, and track implementation of initiatives approved for implementation. | DBHDS implemented a revised Community Look-Behind (CLB) review process in 06/2023 that addresses each of the outcomes required by this Compliance Indicator.<br><br>Monthly sample reviews have been completed for a sample of cases that were closed in the months of 01/2023-06/2023 (25 sample cases/month) with results summarized in the initial *CLB Look-Behind Report for Q3 and Q4 FY23* that was submitted to and reviewed by the RMRC in 08/2023.<br><br>The revised process is well-organized and includes the three outcomes required by this Compliance Indicator and three additional outcomes established by OHR for inclusion in the process.<br><br>Given the newness of the revised process, the RMRC has not yet been given sufficient data and information to identify trends, recommend quality improvement initiatives when necessary, and track | The Community Look-Behind (CLB) is a DBHDS review process conducted by the Office of Human Rights (OHR) for abuse reports among individuals receiving DD services in licensed community provider settings. After a two-year hiatus that resulted from data integrity issues, DBHDS implemented a revised CLB remote review process was initiated in 06/2023. The revised sample case review process conducted by OHR's Regional Managers utilizes a PowerApps automation solution. Currently, the DBHDS revised case review process does not include an inter-rater reliability component pending finalization of the revised process and data automation.<br><br>OHR provided an *OHR Community Look-Behind Timeline* that includes a schedule for monthly reviews and quarterly reports to the RMRC. Sample case reviews began in 06/2023 with a monthly schedule for sample selection and case review from cases closed within the prior month. The sample size is 25 cases/month, and the OHR reviews are conducted on average 20 days after case closure. This represents a significant improvement from DBHDS's prior system where case reviews were conducted sometimes more than one year after the closure of the case.<br><br>The OHR case reviews include evaluation of each of the requirements in this Compliance Indicator (Outcomes 1-3) and three additional outcomes (Outcomes 4-6) established by OHR:<br>• Outcome 1 – Comprehensive and non-partial investigations of individual incidents occur within state-prescribed timelines.<br>• Outcome 2 – The person conducting the investigation has been trained to conduct investigations.<br>• Outcome 3 – Timely, appropriate corrective action plans are implemented by the provider when indicated.<br>• Outcome 4 – Facts of the provider investigation support the director's determination regarding whether the allegation was substantiated.<br>• Outcome 5 – Involved staff were interviewed during the provider investigation.<br>• Outcome 6 – Involved individuals were interviewed. | 22nd - Not Met<br><br>**23rd - Not Met** |

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<tr><th>Compliance Indicator</th><th>Facts</th><th>Analysis</th><th>Conclusion</th></tr>
<tr><td></td><td>implementation of initiatives approved for implementation.</td><td>Results from the initial CLB report (CLB Look-Behind Report for Q3 and Q4 FY23) are summarized in the table below. OHR uses an 86% threshold to measure whether each outcome is met as indicated by reviewer responses to discrete questions in the CLB Review Form. Percentages below the 86% threshold are highlighted in red in the table below:<br><br>
<table>
<tr><th>Outcome</th><th>Q3 Results (Jan-Mar)</th><th>Q4 Results (Apr-Jun)</th></tr>
<tr><td>Sample Size:</td><td>75</td><td>75</td></tr>
<tr><td>Outcome 1:</td><td>62/75 (83%)</td><td>61/75 (81%)</td></tr>
<tr><td>Outcome 2:</td><td>48/75 (64%)</td><td>45/75 (60%)</td></tr>
<tr><td>Outcome 3:</td><td>67/75 (89%)</td><td>65/75 (87%)</td></tr>
<tr><td>Outcome 4:</td><td>65/75 (87%)</td><td>70/75 (93%)</td></tr>
<tr><td>Outcome 5:</td><td>53/75 (71%)</td><td>57/75 (76%)</td></tr>
<tr><td>Outcome 6:</td><td>36/75 (48%)</td><td>26/75 (35%)</td></tr>
</table>
<br>OHR's initial CLB report summarized the results of the case reviews completed for cases closed in the 3rd and 4th quarters of FY23. While the report contains graphics that compare results from prior sample case reviews conducted in CY2020, the data is not fully comparable given that significant changes have been made with implementation of the new system which focuses on improving the accuracy, timeliness, and validity of the CLB process. The RMRC Minutes 8.28.2023 draft described the Committee's review of the initial OHR Community Look-Behind Quarterly Report; however, because this was the first such report submitted using the revised system, trends analysis, recommendations for quality improvement initiatives, and tracking of their implementation by the RMRC are not yet fully operational. The minutes do, however, summarize specific areas that OHR will prioritize for increased focus. These include (1) ensuring that investigators are appropriately trained (Outcome 2) and ensuring staff and individuals involved in the case are interviewed (Outcomes 5 and 6).<br><br>
Due to the newness of the implementation of the DBHDS's revised CLB process, during the 23rd Review Period, the Commonwealth did not meet all of the requirements of this Compliance Indicator. Specifically, with the new CLB process, the RMRC has not yet reviewed trends, recommended quality</td><td></td></tr>
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<tr><td></td><td></td><td>improvement initiatives when necessary, and tracked implementation of initiatives approved for implementation.<br><br>That said, DBHDS has made significant progress toward implementation of improvements in the CLB process since completion of the 22nd study. The current structure of the review process is sound and the significant decrease in lag time between completion of the investigation and completion of the sample look-behind review will contribute to more timely follow-up actions identified to improve the quality of investigations of abuse, neglect, and exploitation. As subsequent quarterly reports are completed, the RMRC will amass sufficient data and information to identify relevant trends and focus areas, recommend quality improvement initiatives when necessary, and track implementation of the initiatives that are approved for implementation.</td><td></td></tr>
<tr><td>29.18<br>At least 86% of the sample of serious incidents reviewed in indicator 5.d meet criteria reviewed in the audit. At least 86% of the sample of allegations of abuse, neglect, and exploitation reviewed in indicator 5.e meet criteria reviewed in the audit.</td><td>DBHDS has achieved the 86% threshold for Outcomes 1 and 2 and the requirements that the RMRC reviews trends at least quarterly, recommends quality improvement initiatives when necessary, and tracks implementation of initiatives approved for implementation as required by Compliance Indicator 29.16. They have not yet achieved the 86% threshold for Outcomes 3 and 4 that address appropriate follow-up from the Office of Licensing Incident Management Unit when necessary and the provider's implementation of timely, appropriate corrective action plans when indicated.</td><td>Details regarding the implementation of the review processes required at CIs 29.16 and 29.17 are described in the previous two sections of this report.<br><br>In review of evidence related to the IMU Look Behind review required at CI 29.16, the following table summarizes data from the three look-behind reviews completed to date. While improvements in three of the four outcomes were noted in Q1 2023, information to measure achievement of Outcome 4 was not available to the VCU reviewers to conduct a full assessment.<br><br><table><tr><th></th><th>Q2 2022</th><th>Q3 2022</th><th>Q1 2023</th></tr><tr><td>Outcome 1</td><td>59%</td><td>78%</td><td>100%</td></tr><tr><td>Outcome 2</td><td>86%</td><td>77%</td><td>90%</td></tr><tr><td>Outcome 3</td><td>73%</td><td>72%</td><td>82%</td></tr><tr><td>Outcome 4</td><td>Not Assessed</td><td>Not Assessed</td><td>Not Assessed</td></tr><tr><td colspan="4">Note: Cells highlighted in red did not meet the threshold requirement</td></tr></table><br>This review verified DBHDS documentation that the RMRC is thoroughly reviewing the findings from each of the VCU quarterly reports and has developed and followed through on process improvement initiatives to address and resolve</td><td>22nd - Not Met<br><br>23rd - Not Met</td></tr>
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<td></td>
<td>DBHDS has achieved the 86% threshold for Outcome 3 required by Compliance Indicator 29.17 addressing the requirement that providers implement timely, appropriate corrective action plans when indicated. They also met the internally established Outcome #4 requiring that facts of the provider investigation support the director's determination regarding whether the allegation was substantiated.<br><br>DBHDS has not yet achieved the 86% threshold for Outcomes 1 and 2 required at Compliance Indicator 29.17 addressing requirements for comprehensive and non-partial investigations of individual incidents occurring within state-prescribed timelines and that the person conducting the investigation be trained to conduct investigations. They have also not met the 86% threshold for internally established Outcomes 5 and 6 that require involved staff and involved individuals be interviewed as part of the</td>
<td>areas of identified concern. To date, these efforts have shown positive impact for Outcomes 1-3; however, Outcome 3 remains below the 86% required threshold and Outcome 4 has not yet been fully assessed.<br><br>In review of evidence related to the Community Look-Behind (CLB) required at CI 29.17, the revised process to conduct these reviews was only recently implemented in 06/2023 with the first quarterly report of results submitted to the RMRC in 08/2023. Results from the initial report (CLB Look-Behind Report for Q3 and Q4 FY23) are summarized in the table below.<br><br>
<table>
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</table>
<br>The results show that Outcomes 1 and 2 do not meet the 86% threshold required in this CI. Additionally, the results for Outcomes 5 and 6 which are not required elements of CI 29.16 but are assessed in the CLB process are also not meeting the 86% threshold established by OHR.<br><br>As the CLB process implementation continues throughout Fiscal Year 2024, the RMRC should continue to review trends, recommend quality improvement initiatives when necessary, and track implementation of initiatives approved for implementation with significant focus on the efforts needed to increase the percentage scores for Outcomes 1 and 2. DBHDS should provide intense technical assistance to providers whose reviews of serious incidents do not meet the criteria reviewed in the audit, specifically focusing on assuring investigations occur within state-prescribed timelines and that investigators are appropriately trained.</td>
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| Compliance Indicator | Facts | Analysis | Conclusion |
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| | investigation.<br><br>Given the newness of the revised CLB process implementation, there has not yet been an opportunity for the RMRC to review trends, recommend quality improvement initiatives when necessary, and track implementation of initiatives approved for implementation. | Virginia did not meet the 86% performance measure required by this Indicator. This Indicator will be met when all of the outcomes required by CIs 29.16 and 29.17 are achieved at or above the 86% threshold. | |

| Compliance Indicator | Facts | Analysis | Conclusion |
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| **29.19**<br>The Commonwealth shall require providers to identify individuals who are at high risk due to medical or behavioral needs or other factors that lead to a SIS level 6 or 7 and to report this information to the Commonwealth. | Overall, DBHDS continued to fulfill the requirements of this CI.<br><br>At the time of the 22nd Period review, DBHDS had a process in place that met the intent of this CI. DBHDS staff provided several documents to describe and attest to the process methodology for providers to identify individuals who are at high risk due to medical or behavioral needs or other factors that lead to a SIS level 6 or 7 or to report this information to the Commonwealth. For this 23rd Period review, DBHDS continued to implement this process as written.<br><br>Also at the time of the 22nd Period review, DBHDS submitted an adequate Process Document entitled *Risk Awareness Tool Review and High Need Review*, which described a series of steps by which an Office of Integrated Health (OIH) Specialist would complete a biannual review a statistically significant sample of RATs completed during the | At the time of the 22nd Period review, DBHDS had a process in place that met the intent of this CI. At that time, DBHDS staff provided several documents to describe and attest to the process methodology for providers to identify individuals who are at high risk due to medical or behavioral needs or other factors that lead to a SIS level 6 or 7 or to report this information to the Commonwealth. In general, this set of documents described a two prong methodology by which Virginia DD Providers identify individuals who are at high risk due to medical or behavioral needs or other factors that lead to a SIS level 6 or 7 and to report this information to the Commonwealth. This included the following:<br>• The completion of the Risk Assessment Tool (RAT) as required (i.e., it appropriately identifies any new potential risk or new diagnosis associated with a potential risk; the new potential risk or diagnosis is identified and documented in the ISP; and whether the potential risk was referred to a qualified health professional.) The RAT is completed by the interdisciplinary team at the time of the ISP and is uploaded to DBHDS. A RAT Summary Page, which is a part of the upload, includes check boxes to identify whether, based on the RAT review, the individual has no potential risk or a potential risk for a changing SIS level (i.e., potential for Level 1,2 or 3; potential for Level 4 or 5; potential for Level 6 or 7). While the process described at the time of the 22nd Period review allowed DBHDS staff to complete a sample review, based on documentation provided, they expected the RAT, including the Summary, to be fully integrated in WaMS by FY 25. At that point, DBHDS should be able to run a report that identifies all individuals with risk factors that have the potential to lead to a Level 6 or 7.<br>• The second methodology is through the *Request for Reassessment of the SIS*, a process based in Virginia *Code12VAC30-122-190.* The Support Intensity Scale (SIS) is utilized to determine the individual's assigned level and tier and needs to be updated as needs change. Reassessment Requests are to be submitted by the individual's Support Coordinator "when the individual's support needs have been deemed to have changed significantly for a sustained period of at least six months." The request for reassessment notifies DBHDS that individuals may have emergent | 22nd - Met<br><br>**23rd - Met** |

| Compliance Indicator | Facts | Analysis | Conclusion |
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| | preceding six month period, and then to provide audit feedback to CSBs and related technical assistance and/or training, as needed, to Support Coordination teams.<br><br>For this 23rd Period review, on 8/24/23, DBHDS staff updated the *Risk Awareness Tool Review and High Need Review* Process Document, but the update did not include any changes to the numerator or denominator or to the process, methodology, or calculations. Therefore, the Data Set Attestation provided for the 22nd Period review, dated 3/10/23, remained current. | high risk medical or behavioral health needs and / or other factors that might lead to a SIS Level 6 or 7. The SIS staff evaluates documentation submitted to identify the needed supports that are not already captured in the current SIS and confirm that they are in fact needed and expected to be on-going. DBHDS also indicated they reviewed data from the process for requesting a reassessment of an individual's SIS level. Using the *SIS Reassessments Spreadsheet*, the reviewer pulls data for the total number of reassessment requests and the numbers of requests that were approved, denied and rejected.<br><br>At the time of the 22nd Period review, DBHDS submitted an adequate Process Document entitled *Risk Awareness Tool Review and High Need Review*, with the most recent revision date of 2/17/23. It described a series of steps by which an Office of Integrated Health (OIH) Specialist would complete a biannual review a statistically significant sample of RATs completed during the preceding six month period, and then to provide audit feedback to CSBs and related technical assistance and/or training, as needed, to Support Coordination teams.<br><br>For this 23rd Period review, DBHDS continued to implement this process as written. On 8/24/23, DBHDS staff updated the *Risk Awareness Tool Review and High Need Review* Process Document, but the update did not include any changes to the numerator or denominator or to the process, methodology, or calculations. Therefore, the Data Set Attestation provided for the 22nd Period review, dated 3/10/23, remained current. | |
| **29.20**<br>At least 86% of the people supported in residential settings will receive an annual physical exam, including review of preventive screenings, and at least 86% of individuals who | This CI was not met because DBHDS data indicated that the Commonwealth did not achieve 86% for annual physical exams for people supported in residential settings or 86% for annual dental exams for individuals who have coverage for dental | At the time of the 22nd Period review, DBHDS reported in the *Developmental Disabilities Annual Report and Evaluation State Fiscal Year 2022*, dated February 17, 2023, that in FY 2022, for the relevant PMI, 74% of individuals in residential settings on the DD waivers had documented annual physical exam date. This remained the most current *Developmental Disabilities Annual Report and Evaluation.*<br><br>DBHDS also submitted a document entitled *Office of Integrated Health Annual Physical and Dental* Exams, dated 8/24/23, which reported the following quarterly percentages of individuals with annual physical exams during FY23: Q1, 74%; | **22nd - Not Met**<br><br>**23rd - Not Met** |

| Compliance Indicator | Facts | Analysis | Conclusion |
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| have coverage for dental services will receive an annual dental exam. | services.<br><br>At the time of the 22nd Period review, DBHDS reported in the Developmental Disabilities Annual Report and Evaluation State Fiscal Year 2022, dated February 17, 2023, that in FY 2022, for the relevant PMI, 74% of individuals in residential settings on the DD waivers had documented annual physical exam date. This remained the most current Developmental Disabilities Annual Report and Evaluation.<br><br>DBHDS also submitted a document entitled *Office of Integrated Health Annual Physical and Dental* Exams, dated 8/24/23, which reported the following quarterly percentages of individuals with annual dental exams during FY23: Q1, 74%; Q2, 76%; Q3, 78% and Q4, 76%. For physical exams, the document reported the following quarterly percentages of individuals during FY23: Q1, 56%; Q2, 57; Q3, 60% and Q4, 63%.<br>For this 23rd Period review, | Q2, 76%; Q3, 78% and Q4, 76%. For dental exams, the document reported the following quarterly percentages of individuals during FY23: Q1, 56%; Q2, 57; Q3, 60% and Q4, 63%.<br><br>Therefore, because DBHDS data indicated that the Commonwealth did not achieve 86% for annual physical exams for people supported in residential settings or 86% for annual dental exams for individuals who have coverage for dental services, this CI was not met. However, it was positive to see the steady incremental growth for physical exams.<br><br>DBHDS has implemented a number of systemic efforts to increase resources for physical and dental exams. In addition, however, DBHDS should implement a monitoring, reporting and technical assistance initiative to ensure that 86% of individuals supported in residential settings receive an annual physical exam, including review of preventive screenings, and at least 86% of individuals who have coverage for dental services will receive an annual dental exam. As a part of this process, DBHDS should engage CSB case management supervision to assist in a focused monitoring of compliance with these requirements.<br><br>At the time of the 22nd Period review, DBHDS provided two Process Documents (*Annual Physical Exams*, *Version 002*, and *Annual Dental Exams*, and a single Data Set Attestation entitled *Physical and Dental Exams*. The Process Document addressed previously identified threats to data validity and reliability with several mitigation strategies, two of which were not yet implemented (i.e., definition of "complete" physical and dental exams, ensuring that ISPs are completed by their effective date).<br><br>For this 23rd Period review, DBHDS provided updated Process Documents (i.e., *Annual Dental Exams Ver 005* and *Annual Physical Exams Ver 005*), both dated 8/24/23, and a single Data Set Attestation, dated 8/4/23.<br><br>Because the most recent Process Documents indicated that DBHDS did not make changes to the numerator or denominator, the process, methodology, or calculations, it appeared the Data Set Attestation was current. It indicated that | |

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| | DBHDS provided updated Process Documents (i.e., *Annual Dental Exams Ver 005* and *Annual Physical Exams Ver 005*), both dated 8/24/23, and a single Data Set Attestation, dated 8/4/23.<br><br>Because the most recent Process Documents indicated that DBHDS did not make changes to the numerator or denominator, the process, methodology, or calculations, it appeared the Data Set Attestation was current. It indicated that the data analyst reviewed mitigation strategies and found that the SME defined a dental and physical exam as requested, reviewed data from the ISPs, worked with the staff from WaMS data to eliminate any potential duplication and completed verification against NCI data to determine consistency of data. However, it did not clearly reference any specific mitigation in place for ensuring that ISPs are completed by their effective date.<br><br>DBHDS also issued a *DQMP* | the data analyst reviewed mitigation strategies and found that the SME defined a dental and physical exam as requested, reviewed data from the ISPs, worked with the staff from WaMS data to eliminate any potential duplication and completed verification against NCI data to determine consistency of data. It did not clearly reference any mitigation for ensuring that ISPs are completed by their effective date.<br><br>DBHDS also issued a *DQMP* document entitled *WaMS Recommendations: Data Source System Enhancement Progress*, with a completion date of 8/4/23.<br><br>It stated its purpose was to assess the current progress regarding the Actionable Recommendations from the previous assessment of WaMS. It included a comprehensive list of the initial threats to data validity and reliability previously outlined, along with the corresponding measures taken to address and mitigate these threats. Further, it stated the primary objective was to evaluate whether actions taken to address identified concerns successfully meet the requirements of the business area and effectively mitigate the identified threats. This document indicated that with regard to ensuring that ISPs are completed by their effective date, that DBHDS was still making changes to the quarterly ISP Compliance report format to include the number and percentage of ISPs not placed in the proper status before the effective date of the related ISP year and that this modification will be considered when issuing corrective action plan requests and providing technical assistance starting in FY24.<br><br>Therefore, it remained unclear whether the Process Documents included sufficient mitigation strategies to address this threat to data validity and reliability. Going forward, DBHDS should clarify. | |

| Compliance Indicator | Facts | Analysis | Conclusion |
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| | document entitled *WaMS Recommendations: Data Source System Enhancement Progress*, with a completion date of 8/4/23. Its stated purpose was to assess the current progress regarding the Actionable Recommendations from the previous assessment of WaMS. The primary objective was to evaluate whether actions taken to address identified concerns successfully meet the requirements of the business area and effectively mitigate the identified threats. This document indicated that with regard to ensuring that ISPs are completed by their effective date, that DBHDS was still making changes to the quarterly ISP Compliance report format to include the number and percentage of ISPs not placed in the proper status before the effective date of the related ISP year and that this modification would be considered when issuing corrective action plan requests and providing technical assistance starting in FY24.<br><br>Therefore, it remained unclear whether the Process | | |

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| | Documents included sufficient mitigation strategies to address this threat to data validity and reliability. Going forward, DBHDS should clarify. | | |
| **29.21**<br>At least 86% of people with identified behavioral support needs are provided adequate and appropriately delivered behavioral support services. | DBHDS reports its progress meeting the requirements of CI 29.21 in the FY24 Q1 Crisis Report. The data used to determine the Commonwealth's level of compliance is the percentage of behavioral plans reviewed using the BSPARI tool that achieve 34 of 40 points indicating that the plan meets 85% of the criteria for adequacy and appropriateness. | For this 23rd Period review, DBHDS did not yet achieve compliance with CI 29. 21.During this review cycle, 59 of the 120 (49%) behavioral plans reviewed achieved 34 points. | 22nd - Not Met<br><br>**23rd - Not Met** |
| **29.22**<br>At least 95% of residential service recipients reside in a location that is integrated in, and supports full access to the greater community, in compliance with CMS rules on Home and Community-based Settings. | The Commonwealth did not meet the requirements of this CI because it did not submit a data report to evidence compliance. In addition, the measure was not a valid indicator of the total percentage of residential service recipients residing in a location that is integrated in, and supports full access to the greater community, in compliance with CMS rules on Home and Community-based Setting. It counted individuals | For the 22nd review, DBHDS did not provide a written data report, but verbally reported some partial data that were not sufficient to evidence the status of compliance overall. For the 23rd Period review, DBHDS did not provide a written data report. Therefore, this CI was not met.<br><br>DBHDS should ensure that its monitoring and reporting process provides reliable and valid data of the total percentage of residential service recipients residing in a location that is integrated in, and supports full access to the greater community as well as any evidence that noncompliance had been successfully remediated. First, DBHDS must therefore ensure a valid methodology is in place that does not include QSR data regarding the presence of a provider CAP for HCBS compliance, but rather the verification that the CAP has been successfully implemented. The Commonwealth's Medicaid Home and Community-Based Services Settings Regulations Corrective Action Plan indicates the Commonwealth does not expect to complete validation of the QSR residential | 22nd - Not Met<br><br>**23rd - Not Met** |

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| | who lived in settings for which the QSR vendor found noncompliance and issued a quality improvement plan, but without any evidence that the noncompliance had been successfully remediated. Of note, based on a *Medicaid Home and Community-Based Services Settings Regulations Corrective Action Plan for the State of Virginia*, approved by CMS effective 6/20/23, the Commonwealth does not expect to complete validation of the QSR residential settings findings with regard to HCBS compliance until 6/30/25.<br><br>For this 23rd Period review, DBHDS submitted a Process Document, entitled *HCBS Settings (Version 002),* updated 8/17/23; however, it relied upon the invalid measure. DBHDS did not submit an Attestation. | settings findings with regard to HCBS compliance until 6/30/25. For the purpose of achieving compliance within the SA timeline, the Commonwealth should re-evaluate this timeline and devote additional resources to the validation process.<br><br>With regard to data validity and reliability, at the time of the 22nd Period review, DBHDS provided a Process Document, entitled *HCBS Settings (Version 1*), dated 1/1/23. It indicated that, going forward, the data to be reported would include both the number and percentage of compliant settings and the number and percentage of people living in compliant settings. The Process Document stated that DBHDS intended to rely on data from WaMS, CONNECT and the HCBS Master Tracking Spreadsheet maintained by DMAS to confirm compliance. The WaMS report would provide the number of individuals authorized by residential service type by provider, CONNECT data would provide the number of licensed provider locations by residential services type and the number served in each location and the HCBS Master Tracking Spreadsheet would provide the names of provider locations that have been found to be in compliance (i.e., have received a compliance letter) with the Settings Rule.<br><br>The Process Document also sought to incorporate QSR findings, based on HCBS questions that were added for Round 5. It stated that the HCBS Master Tracking Spreadsheet would be cross-referenced with a pending and yet unnamed QSR report that will be filtered to identify any setting that received a full QSR review for the period in question. In that event, the Process Document indicated that those settings will be considered compliant "since the provider will have to implement their quality plan."<br><br>At the time of the 22nd Period review, this study found that DBHDS would need to re-consider this portion of the methodology. A plan to achieve compliance does not equate to compliance and therefore would invalidate this measure. At best, these settings would have to be considered as in remediation until such time successful completion of that remediation can be validated. Of note, based on a *Medicaid Home and Community-Based Services Settings Regulations Corrective Action Plan for the State of Virginia*, approved by CMS effective 6/20/23, the Commonwealth | |

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| | | does not expect to complete validation of the QSR residential settings findings with regard to HCBS compliance until 6/30/25.<br><br>For this 23rd Period review, DBHDS provided a Process Document entitled *HCBS Settings (Version 002)*, updated 8/17/23. It indicated the update made no changes to process, methodology, or calculations and a review of the document confirmed this was accurate. Therefore, the methodology for this 23rd Period was not valid for this measure.<br><br>DBHDS did not provide an Attestation for this measure. Going forward, DBHD will also need to ensure that Process Documents and Attestations are in place for the use of the data from WaMS, CONNECT and the HCBS Master Tracking Spreadsheet maintained by DMAS. | |
| **29.23**<br>At least 95% of individual service recipients are free from neglect and abuse by paid support staff. | For the 23rd Period review, DBHDS provided ANE data for the four quarters of SFY23, which showed DBHDS exceeded 98% for each quarter. Based on these data, DBHDS met the requirements of this CI.<br><br>For this 23rd Period review, DBHDS submitted a revised Process Document entitled *HR Process Document Free From ANE 29.23 VER005*, dated 10/12/23. This version added clarifying language to Steps 4 and 5 regarding the process used to identify substantiated reports; added actions to Step 7 to correct against potential | For the 23rd Period review, DBHDS provided the following ANE data for the four quarters of SFY23:<br>Q1: 15,444-202/15,444 =98.6%<br>Q2: 15,606-188/15,606=98.7%<br>Q3: 15,741-212/15,741=98.6%<br>Q4: 15,826-225/15,826=98.5%<br><br>Based on these data, DBHDS met the requirements of this CI.<br><br>The 22nd Period study identified several factors in the Process Document methodology at that time that rendered it insufficient to determine the validity and reliability of the data. For this 23rd Period review, DBHDS submitted a revised Process Document entitled *HR Process Document Free From ANE 29.23 VER005*, dated 10/12/23. This version added clarifying language to Steps 4 and 5 regarding the process used to identify substantiated reports; added actions to Step 7 to correct against potential overcounting due to duplication across *DW-0033a* and *DW-0038a*; clarified exploitation is defined as a type of abuse and clarified the operational definition of the term "paid support staff." These modifications addressed the previously identified deficiencies. | 22nd - Not Met<br><br>**23rd - Met** |

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| | overcounting due to duplication across *DW-0033a* and *DW-0038a*; clarified exploitation is defined as a type of abuse and clarified the operational definition of the term "paid support staff." These modifications addressed the previously identified deficiencies.<br><br>DBHDS also provided a Data Set Attestation for this Process Document, dated 8/30/23. While it met the requirements of the *Curative Action for Data Validity and Reliability* overall, going forward, the CDO should review the recent modifications to the methodology and re-attest to reliability and validity. | DBHDS also provided a Data Set Attestation for this Process Document, dated 8/30/23. While it met the requirements of the Curative Action for Data Validity and Reliability overall, going forward, the CDO should review the recent modifications to the methodology and re-attest to reliability and validity. | |
| **29.24**<br>At least 95% of individual service recipients are adequately protected from serious injuries in service settings. | The Commonwealth did not meet the requirements of this CI because DBHDS reported that 88.7% of individual service recipients were adequately protected from serious injuries in service settings. This did not meet the requirement of this CI.<br><br>Moreover, DBHDS still | For this 23rd Period review, DBHDS reported that 88.7% of individual service recipients were adequately protected from serious injuries in service settings. This did not meet the requirement of this CI.<br><br>Moreover, DBHDS still needed to ensure the measure methodology would produce valid and reliable data. First, while the rationale DBHDS provided was based on a recognition that even with the best of planning and implementation, some serious injuries will still occur, DBHDS did not provide evidence they considered whether the outcome for people served (i.e., the rate at which individuals experience serious injuries) should be considered in the overall definition of adequacy. In other words, the adequacy of the processes DBHDS | 22nd - Not Met<br><br>**23rd - Not Met** |

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| | needed to ensure the measure methodology would produce valid and reliable data. The current methodology focused solely on whether DBHDS's risk mitigation planning process was implemented and did not consider or incorporate an objective measure of the percentage of individuals who sustained serious injuries in service settings (i.e., the outcome for individual service recipients).<br><br>It was also not clear that DBHDS has sufficient data capabilities at this time to allow for an adequate evaluation of serious injury data. For example, a CHRIS Level II report dated in August 2023 indicated that for FY23, there were 605 "serious injuries requiring medical attention" reported, the same report documented 6410 ER visits and 1677 unplanned hospitalizations for which the cause was not defined. In interview, DBHDS staff acknowledged that this could include an unknown number of serious injuries. | implements to protect individual service recipients from serious injuries in service settings cannot be fully evaluated without some measure of the rate at which those individuals experience serious injuries. For example, should there be a threshold of individual service recipients sustaining serious injuries in service settings that, if reached, should trigger an analysis of the adequacy of the risk planning and implementation processes themselves, in spite of data that might show those processes stood at 95% compliance?<br><br>The seriousness of the lack of an outcome component becomes more apparent when assessing whether DBHDS has sufficient data capabilities at this time to allow for an adequate evaluation of serious injury data. For example, a CHRIS Level II report dated in August 2023 indicated that for FY23, there were 605 "serious injuries requiring medical attention" reported, the same report documented 6410 ER visits and 1677 unplanned hospitalizations for which the cause was not defined. In interview, DBHDS staff acknowledged that this could an unknown number of serious injuries. They also reported that some of this functionality was still being developed.<br><br>In addition to this concern about serious injury outcomes for people served, questions also remained about the reliability of the process data this measure would utilize. For context, at the time of the 22nd Period review, the RMRC minutes proposed Support Coordination Quality Review (SCQR) process, Indicator 7 as the method for measuring this CI. This measure read "The case manager assesses risk, and risk mediation plans are in place as determined by the ISP team." It consisted of two questions: "Does the PC ISP Essential Information indicate that the SC assessed for risk?" and "Did the ISP team develop a risk mediation plan?" At that time, this study found significant questions about the reliability of the CSB self-reported data. The SCQR documentation at that time provided showed that although the inter-rater reliability among DBHDS OCQI reviewers was strong, the agreement between CSB and DBHDS look-behind reviewers was weak.<br><br>At the time of the 22nd Period review, DBHDS provided a Process Document entitled *Individuals Protected from Injury, Ver 001*, dated 3/27/23, and a Data Set Attestation for the SCQR, dated 3/9/22. For this 23rd Period review, DBHDS | |

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| | For this 23rd Period review, DBHDS provided a Process Document entitled *Individuals Protected from Injury Ver 002*, dated 8/24/23, and a Data Set Attestation, dated 10/16/23. In addition to not addressing how DBHDS would factor in the actual percentage of serious injuries (i.e., the outcome for people served) to the determination of adequacy, the Process Document indicated the measure still largely relied on the SCQR process, Indicator 7, as the method for measuring this CI, which did not yet appear to yield reliable data. While there was some slight improvement in the rate of agreement (i.e., from .44 to .46) between the CSB reviews and the OCQI look-behind overall, it was still below the FY 21 rate of .50 and only barely moved from the weak agreement to the moderate agreement range. It was one of only two indicators in the SCQR that did not show substantial agreement.<br><br>The Process Document also indicated that DBHDS was | provided a Process Document entitled *Individuals Protected from Injury Ver 002*, dated 8/24/23, and a related Data Set Attestation, dated 10/16/23. The following describes remaining concerns that DBHDS should address going forward:<br>• The measure still largely relied on the SCQR process, Indicator 7, as the method for measuring this CI, which did not yet appear to yield reliable data. While there was some slight improvement in the rate of agreement (i.e., from .44 to .46) between the CSB reviews and the OCQI look-behind overall, it was still below the FY 21 rate of .50 and only barely moved from the weak agreement to the moderate agreement range. In fact, it was one of only two indicators in the SCQR that did not show substantial agreement.<br>• RMRC minutes indicated that the members agreed the methodology could be considered valid because the OCQI reviewers had good inter-rater reliability. However, OCQI scores were not the basis for the measure reporting and therefore should not form the basis for the committee members' assessment of the measure's *current* reliability and validity.<br>• As described above, the Process Document still did not address how DBHDS would factor in the actual percentage of serious injuries (i.e., the outcome for people served) to the determination of adequacy.<br>• The Process Document indicated that DBHDS was adding Outcome 4 from the IMU look-behind (i.e., whether, for certain care concerns, timely, appropriate corrective action plans are implemented by the provider when indicated) as a second measure, but it was not clear the care concerns reviewed in the outcome were relevant to serious injuries. In interview, DBHDS staff acknowledged this might not be an appropriate measurement component. The Process Document also did not define how the two measures would be factored to provide an overall compliance score.<br>• The Data Set Attestation indicated the data were valid and reliable for the identification of quality improvements and risk mitigation, but did not indicate that existing risk mitigation strategies were sufficient to produce valid and reliable data of the measure itself. | |

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| | adding Outcome 4 from the IMU look-behind (i.e., whether, for certain care concerns, timely, appropriate corrective action plans are implemented by the provider when indicated) as a second measure, but it was not clear the care concerns reviewed in the outcome were relevant to serious injuries. In interview, DBHDS staff acknowledged this might not be an appropriate measurement component. The Process Document also did not define how the two measures would be factored to provide an overall compliance score.<br><br>The applicable Data Set Attestation, dated 10/16/23, indicated the data were valid and reliable for the identification of quality improvements and risk mitigation, but did not indicate that existing risk mitigation strategies were sufficient to produce valid and reliable data for the measure itself. | | |
| **29.25**<br>For 95% of individual | Overall, DBHDS fulfilled the requirements of this Indicator. | The *Developmental Disabilities Annual Report and Evaluation State Fiscal Year 2022* (i.e., the most recent version) reported performance at 99% for recipients, seclusion or | 22nd - Not Met |

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| 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. | The *Developmental Disabilities Annual Report and Evaluation State Fiscal Year 2022*, which is the most recent version, reported performance at 99% for 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. This exceeded the requirements of this CI.<br><br>For this 23rd Period review, DBHDS submitted a revised Process Document entitled *HR Process Document 29.25 VER005,* dated 6/20/23. This version updated the mitigation section to address threats of data validity and reliability, clarified the calculation of the numerator to include subtraction of total number unauthorized seclusion/restraint from total number of individuals on waiver, addressed the threat of potential overcounting, and added definitions for seclusion | 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. This exceeded the requirements of this CI.<br><br>At the time of the 22nd Period, DBHDS submitted a Process Document entitled *HR Process Document 29.5 Version 002*, last revised on 4/19/22, that substantively modified the data collection methodology from the previous process, but it was not yet sufficient to determine the validity and reliability of the data. The study at that time found deficiencies that could impact data validity and reliability.<br><br>For this 23rd Period review, DBHDS submitted a revised Process Document entitled *HR Process Document 29.25 VER005,* dated 6/20/23. This version updated the mitigation section to address threats of data validity and reliability, clarified the calculation of the numerator to include subtraction of total number unauthorized seclusion/restraint from total number of individuals on waiver, addressed the threat of potential overcounting, and added definitions for seclusion and restraint. These modifications addressed the previously identified deficiencies.<br><br>DBHDS also provided a Data Set Attestation for this Process Document, dated 9/1/23. It met the requirements of the Curative Action for Data Validity and Reliability overall. | **23rd - Met** |

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| | and restraint. These modifications addressed the previously identified deficiencies.<br><br>DBHDS also provided a Data Set Attestation for this Process Document, dated 9/1/23. It met the requirements of the *Curative Action for Data Validity and Reliability* overall. | | |
| **29.26**<br>The Commonwealth ensures that at least 95% of applicants assigned to Priority 1 of the waiting list are not institutionalized while waiting for services unless the recipient chooses otherwise or enters into a nursing facility for medical rehabilitation or for a stay of 90 days or less. Medical rehabilitation is a non-permanent, prescriber-driven regimen that would afford an individual an opportunity to improve function through the professional | Overall, DBHDS fulfilled the requirements of this Indicator.<br><br>Based on four quarterly reports of the *Supplemental Crisis Report*, DBHDS was achieving this measure. During both the first and second quarters of FY23, 99.7% of people on the Priority 1 waiting list were not institutionalized. During the 3rd quarter of FY23, DBHDS reported a figure of 99.8%, while in 4th quarter of FY23, the figure was 99.9%. Therefore, for the last four reported quarters, DBHDS exceeded the requirement for this CI for each of the quarters reported. | Based on four quarterly reports of the *Supplemental Crisis Report*, DBHDS was achieving this measure. During both the first and second quarters of FY23, 99.7% of people on the Priority 1 waiting list were not institutionalized. During the 3rd quarter of FY23, DBHDS reported a figure of 99.8%, while in 4th quarter of FY23, the figure was 99.9%. Therefore, for the last four reported quarters, DBHDS exceeded the requirement for this CI for each of the quarters reported.<br><br>For the 22nd Period review, DBHDS provided a Process Document entitled *DD Priority 1 VER 004*, dated 1/10/23. Based on review, the methodology relied on various other data sets to derive the data for the numerator and denominator, including: *SH-IDDD Hospitalizations* with data from AVATAR; *REACH Hospital Tracker Private Hospitalizations*; *ICF-IDD Admissions Data* from the Family Resource Consultant; *PASS-R Data* from nursing facilities admission data and the *Priority 1 Waitlist by CSB Data* from WaMS. The study found that the Process Document provided a detailed and carefully constructed methodology for how to pull and organize the data reports from the other sources to derive the numerator and denominator for this CI. This included the identification of previously identified threats to validity and reliability for WaMS and AVATAR data that were applicable to this measure, accompanied by an explanation of the mitigating strategies in place. However, DBHDS staff still needed to ensure that the | 22nd - Met*<br><br>**23rd - Met** |

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| supervision and direction of physical, occupational, or speech therapies. Medical rehabilitation is self-limiting and is driven by the progress of the individual in relation to the therapy provided. When no further progress can be documented, individual therapy orders must cease. | DBHDS provided a Process Document entitled *DD Priority 1VER 005,* dated 8/17/23. It made no changes to process, methodology, or calculations from the previous version. The Process Document continued to provide a detailed and carefully constructed methodology for how to pull and organize the data reports from the other sources to derive the numerator and denominator for this CI. Updates addressed concerns previously identified, including the provision of the related Process Documents (*CSS Hospital Admits & Trends Process_VER002, process (REACH Hospital Tracker, Avatar data), PASRR- Data Collection VER001, ICF IID Admission Packet Reviews VER001, WaMS - Reports - SOP 7.2023, 7.10, 7.12, 7.13 DD HOSP NOT VER 001*) and respective Attestations.<br><br>DBHDS also provided a Data Set Attestation entitled Data Set Attestation for the *Supplemental Crisis Report Data Set,* dated 8/31/23, as it related to this referenced | underlying data from each of these processes also met the requirements of the Curative Action for Data Validity and Reliability. For example, in order to fully evaluate the validity and reliability of data for this CI, it would be necessary to ensure that the data reported from the other data sets sufficiently took into account through definitions and/or process steps whether recipient chose institutionalization, entered into a nursing facility for medical rehabilitation or for a stay of 90 days or less or was receiving medical rehabilitation.<br><br>For the 23rd Period review, DBHDS provided an updated Process Document entitled *DD Priority 1VER_005,* dated 8/17/23. It made no changes to process, methodology, or calculations from the previous version and continued to provide a detailed and carefully constructed methodology for how to pull and organize the data reports from the other sources to derive the numerator and denominator for this CI. The Process Document also continued to indicate that the process required review and comparison of the numerous data sets identified above. Based on a document entitled *CI 29.26: Progress since the last review, 8/2023*, the updates addressed the concerns previously identified, including the provision of the related Process Documents (*CSS Hospital Admits & Trends Process_VER002, process (REACH Hospital Tracker, Avatar data), PASRR- Data Collection VER001, ICF IID Admission Packet Reviews VER001, WaMS - Reports - SOP 7.2023, 7.10, 7.12, 7.13 DD HOSP NOT VER 001*) and respective Attestations.<br><br>For the 23rd Period review, DBHDS also provided a Data Set Attestation entitled *Supplemental Crisis Report Data Set*, dated 8/31/23, as it related to this referenced Process Document. It attested to how to pull data from the data set, and to the sufficiency of the Process Document mitigation steps for addressing threats to reliability and validity based on deficiencies that potentially emanated from data entry concerns. This met the requirements of the Curative Action for Data Validity and Reliability overall.<br><br>. | |

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| | Process Document. It met the requirements of the *Curative Action for Data Validity* and Reliability overall. | | |
| **29.27**<br>At least 75% of people with a job in the community chose or had some input in choosing their job. | Overall, DBHDS fulfilled the requirements of this Indicator.<br><br>According to the Process Document entitled *Provider Data Summary VER 001*, dated 3/13/23, the NCI remained the data source for this CI, but the *Provider Data Summary* includes the performance data reporting for this CI.<br><br>*Provider Data Summary State Fiscal Year May 2023,* dated 9/15/23, the results from the *National Core Indicators In-Person Survey (IPS) State Report 2020-21 Virginia Report* indicate that a combined 92% (n=52) either chose or had some input on choosing their job. The *Provider Data Summary* noted this was a positive increase of 2% when compared to the previous 2019-2020 report. Based on this, the CI was met.<br><br>NCI data may be considered reliable and valid. For this 23rd Period review, DBHDS | Consistent with the study at the time of the 22nd Period review, the *Provider Data Summary* includes the performance data reporting for this CI, but the NCI remains the data source. Based on the *Provider Data Summary State Fiscal Year May 2023,* dated 9/15/23, the results from the *National Core Indicators In-Person Survey (IPS) State Report 2020-21 Virginia Report* indicate that a combined 92% (n=52) either chose or had some input on choosing their job. The *Provider Data Summary* noted this was a positive increase of 2% when compared to the previous 2019-2020 report. Based on this, the *Provider Data Summary* concluded the measure was met.<br><br>As described above with regard to CI 29.8, NCI data may be considered reliable and valid. DBHDS previously provided a Data Set Attestation Form for the *NCI Adult Consumer Survey* data set that referenced the external documentation that evidenced this. For this 23rd Period review, DBHDS also provided Process Documents entitled *DD Provider Data Summary Ver 011* (Indicator 29.27-29.33), dated 8/17/23, and *Provider Data Summary VER 012*, dated 9/6/23. The most recent Data Set Attestation, dated 8/30/23, was sufficient for this CI, since *Version 012* did not make any changes to the relevant calculation or mitigation strategies. | 22nd - Met<br><br>**23rd - Met** |

| Compliance Indicator | Facts | Analysis | Conclusion |
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| | also provided Process Documents entitled *DD Provider Data Summary Ver 0011* (Indicator 29.27-29.33), dated 8/17/23, and *Provider Data Summary VER 012*, dated 9/6/23. The most recent Data Set Attestation dated 8/30/23 was sufficient for this CI, since *Version 012* did not make any changes to the relevant calculation or mitigation strategies. | | |
| **29.28**<br>At least 86% of people receiving services in residential services/their authorized representatives choose or help decide their daily schedule. | Overall, DBHDS fulfilled the requirements of this Indicator.<br><br>The *Provider Data Summary State Fiscal Year May 2023,* dated 9/15/23, reported the data for this measure as follows: 100% for Q4 FY22 and Q1 FY23. This exceeded the requirement for this CI.<br><br>For this 23rd Period review, DBHDS submitted two Process Documents entitled *DD Provider Data Summary Ver 0011 (Indicator 29.27-29.33),* dated 8/17/23, and *Provider Data Summary VER 012*, dated 9/6/23. These addressed each of the concerns from the previous review. While some of | The *Provider Data Summary State Fiscal Year May 2023,* dated 9/15/23, indicated that the data for this measure was derived from *WaMS ISP Quarterly Aggregate Reports* by combining the numerators and then the denominators for FY22 Quarters 2 and 3 in each instance. It reported the data for this measure as follows: 100% for Q4 FY22 and Q1 FY23. This exceeded the requirement for this CI.<br><br>At the time of the 22nd Period review, the study found that data collection methodology for this CI did not yield valid and reliable data. At that time, the Process Document did not address all of the process steps for creating the data source (i.e., the *WaMS ISP Quarterly Aggregate Report*), did not state the numerator and denominator, and did not reference this measure among those to which the mitigation timelines are applicable. In addition, DBHDS needed to update the Process Document as they finalized pending the mitigation strategies, some of which were some of the mitigation strategies were only recently implemented at the time of the 22nd Period and not in place at the time the data reported were derived, or had not yet been implemented, but were in planning or pending status.<br><br>For this 23rd Period review, DBHDS submitted two Process Documents entitled *DD Provider Data Summary Ver 0011 (Indicator 29.27-29.33),* dated 8/17/23, and | 22nd-Met*<br><br>**23rd - Met** |

| Compliance Indicator | Facts | Analysis | Conclusion |
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| | the mitigation strategies had not yet been implemented, but were in planning or pending status, it appeared they would be sufficient for this measure.<br><br>The most recent Data Set Attestation dated 8/30/23 was sufficient for this CI, since *Version 012* did not make any changes to the relevant calculation or mitigation strategies. | *Provider Data Summary VER 012*, dated 9/6/23. *DD Provider Data Summary Ver 0011* addressed each of the concerns from the previous review. While some of the mitigation strategies had not yet been implemented, but were in planning or pending status, it appeared they would be sufficient for this measure.<br><br>The most recent Data Set Attestation dated 8/30/23 was sufficient for this CI, since *Version 012* did not make any changes to the relevant calculation or mitigation strategies. | |
| **29.29**<br>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. | Overall, DBHDS fulfilled the requirements of this Indicator.<br><br>The *Provider Data Summary State Fiscal Year May 2023*, dated 9/15/23, reported the data for this measure as follows: 100% for Q2 FY23 and Q3 FY23. This exceeded the requirement for this CI.<br><br>For this 23rd Period review, DBHDS submitted two Process Documents entitled *DD Provider Data Summary Ver 0011 (Indicator 29.27-29.33)*, dated 8/17/23, and *Provider Data Summary VER012*, dated 9/6/23. These addressed each of the concerns from the | The *Provider Data Summary State Fiscal Year May 2023,* dated 9/15/23, indicated that the data for this measure was derived from *WaMS ISP Quarterly Aggregate Reports* by combining the numerators and then the denominators for FY23 Quarters 2 and 3 in each instance. It reported the data for this measure as follows: 100% for Q2 FY23 and Q3 FY23. This exceeded the requirement for this CI.<br><br>At the time of the 22nd Period review, the study found that data collection methodology for this CI did not yield valid and reliable data. At that time, the Process Document did not address all of the process steps for creating the data source, the *WaMS ISP Quarterly Aggregate Report*. In addition, DBHDS needed to update the Process Document as they finalized pending the mitigation strategies, some of which were some of the mitigation strategies were only recently implemented at the time of the 22nd Period and not in place at the time the data reported were derived, or had not yet been implemented, but were in planning or pending status.<br><br>For this 23rd Period review, DBHDS submitted two Process Documents entitled *DD Provider Data Summary Ver* 0011 (Indicator 29.27-29.33), dated 8/17/23, and *Provider Data Summary VER 012*, dated 9/6/23. *DD Provider Data Summary Ver 0011* | 22nd - Met*<br><br>**23rd - Met** |

| Compliance Indicator | Facts | Analysis | Conclusion |
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| | previous review. While some of the mitigation strategies were only recently implemented and were not in place at the time the data reported above was derived, or had not yet been implemented, but were in planning or pending status, it appeared they would be sufficient for this measure. | addressed each of the concerns from the previous review. While some of the mitigation strategies were only recently implemented and were not in place at the time the data reported above was derived, or had not yet been implemented, but were in planning or pending status, it appeared they would be sufficient for this measure.<br><br>The most recent Data Set Attestation dated 8/30/23 was sufficient for this CI, since Version 012 did not make any changes to the relevant calculation or mitigation strategies. | |
| **29.30**<br>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. | Overall, DBHDS fulfilled the requirements of this Indicator.<br><br>The *Provider Data Summary State Fiscal Year May 2023*, dated 9/15/23, reported the data for this measure as follows: 99.9% for Q4 FY22 and 99.8% for Q1 FY23. This exceeded the requirement for this CI.<br><br>For this 23rd Period review, DBHDS submitted two Process Documents entitled *DD Provider Data Summary Ver 0011 (Indicator 29.27-29.33)*, dated 8/17/23, and *Provider Data Summary VER 012*, dated 9/6/23. These addressed each of the concerns from the previous review. While some of | The *Provider Data Summary State Fiscal Year May 2023*, dated 9/15/23, reported the data for this measure as follows: 99.9% for Q4 FY22 and 99.8% for Q1 FY23. This exceeded the requirement for this CI.<br><br>At the time of the 22nd Period review, the study found that data collection methodology for this CI did not yield valid and reliable data. At that time. the Process Document did not address all of the process steps for creating the data source, the *WaMS ISP Quarterly Aggregate Report*. In addition, DBHDS needed to update the Process Document as they finalized pending the mitigation strategies, some of which were some of the mitigation strategies were only recently implemented at the time of the 22nd Period and not in place at the time the data reported were derived, or had not yet been implemented, but were in planning or pending status.<br><br>For this 23rd Period review, DBHDS submitted two Process Documents entitled *DD Provider Data Summary Ver 0011 (Indicator 29.27-29.33)*, dated 8/17/23, and *Provider Data Summary VER 012*, dated 9/6/23. *DD Provider Data Summary Ver 0011* addressed each of the concerns from the previous review.<br><br>The most recent Data Set Attestation dated 8/30/23 was sufficient for this CI, since Version 012 did not make any changes to the relevant calculation or | 22nd - Met*<br><br>**23rd - Met** |

| Compliance Indicator | Facts | Analysis | Conclusion |
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| | the mitigation strategies were only recently implemented and were not in place at the time the data reported above was derived, or had not yet been implemented, but were in planning or pending status, it appeared they would be sufficient for this measure.<br><br>The most recent Data Set Attestation dated 8/30/23 was sufficient for this CI, since Version 012 did not make any changes to the relevant calculation or mitigation strategies. | mitigation strategies. | |
| **29.33**<br>The Commonwealth ensures that individuals have choice in all aspects of their goals and supports as measured by the following: a. At least 95% of people receiving services/authorized representatives participate in the development of their own service plan. | Overall, DBHDS fulfilled the requirements of this Indicator.<br><br>The *Provider Data Summary State Fiscal Year May 2023*, dated 9/15/23 reported the data for this measure as follows: 99.9% for Q4 FY22 and 100% for Q1 FY23. This exceeded the requirement for this CI.<br><br>For this 23rd Period review, DBHDS submitted two Process Documents entitled *DD Provider Data Summary Ver 0011 (Indicator 29.27-29.33)*, | The *Provider Data Summary State Fiscal Year May 2023*, dated 9/15/23, reported the data for this measure as follows: 99.9% for Q4 FY22 and 100% for Q1 FY23. This exceeded the requirement for this CI.<br><br>At the time of the 22nd Period review, the study found that data collection methodology for this CI did not yield valid and reliable data. At that time, the Process Document needed to state it addressed CI 29.33 and did not address all of the process steps for creating the data source (i.e., the *WaMS ISP Quarterly Aggregate Report*). In addition, DBHDS needed to update the Process Document as they finalized pending the mitigation strategies, some of which were some of the mitigation strategies were only recently implemented at the time of the 22nd Period and not in place at the time the data reported were derived, or had not yet been implemented, but were in planning or pending status. For this 23rd Period review, DBHDS submitted two Process Documents entitled *DD Provider Data Summary Ver 0011 (Indicator 29.27-29.33)*, dated 8/17/23, and *Provider Data Summary VER 012*, dated 9/6/23. *DD Provider Data Summary Ver 0011* addressed | 22nd – Met*<br><br>**23rd – Met** |

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| | dated 8/17/23, and *Provider Data Summary VER 012*, dated 9/6/23. These addressed each of the concerns from the previous review.<br><br>The most recent Data Set Attestation, dated 8/30/23, was sufficient for this CI, since Version 012 did not make any changes to the relevant calculation or mitigation strategies. | each of the concerns from the previous review. While some of the mitigation strategies were only recently implemented and were not in place at the time the data reported above was derived, or had not yet been implemented, but were in planning or pending status, it appeared they would be sufficient for this measure.<br><br>The most recent Data Set Attestation dated 8/30/23 was sufficient for this CI, since *Version 012* did not make any changes to the relevant calculation or mitigation strategies. | |

## V.C.1 Analysis of 23rd Review Period Findings

**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. Harm includes any physical injury, whether caused by abuse, neglect, or accidental causes.**

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| **30.4:**<br>At least 86% of DBHDS-licensed providers of DD services have been assessed for their compliance with risk management requirements in the Licensing Regulations during their annual inspections.<br><br>Inspections will include an assessment of whether providers use data at the individual and provider level, including, at minimum, data from incidents and investigations, to identify and address trends and patterns of harm and risk of harm in the events reported, as well as the associated findings and recommendations. This includes identifying year-over-year trends and | The DBHDS annual licensing inspection includes an assessment of whether the provider's risk management program complies with relevant requirements in the Licensing Regulations at *§520.A-D* and the additional requirements in this Compliance Indicator that providers use data at the individual and provider level to identify and address trends and patterns of harm and risk of harm in the events reported as well as the associated findings and recommendations.<br><br>DBHDS added specific instructions to the *OL Annual Compliance Determination Chart-2023* that require citation of *§520.C.5* if the provider is not using data at the individual and provider level to identify and address trends and patterns of harm and risk of | To address concerns noted in the 18th, 20th, and 22nd study reports, the *OL Annual Compliance Determination Chart -2023* was revised to require the provider to be cited at 520.C.5 "if their review of serious incidents does not include evidence that the provider completed an analysis of trends from their quarterly review of serious incidents, identified potential systemic issues or causes, indicated remediation, and planned/implemented steps taken to mitigate the potential for future incidents. This includes identifying year-over-year trends and patterns and the use of baseline data to assess the effectiveness of risk management systems." While the licensing regulations at §520.C.1-5 do not explicitly include this language, the *OL Annual Compliance Determination Chart-2023* instructs licensing specialists to assess this as a part of their determination of whether the provider is meeting the requirements at 520.C.5. OL has provided training to providers and licensing specialists regarding the additional language added to these requirements.<br><br>DBHDS supplied a *Process Document: (30.4, 30.5, 30.7 DOJ Process RM Requirements VER005)* and *Attestation Statement: (30.4, 30.5, 30.7 RM Requirements Attachment B – 8.30.2023)* addressing the data that it used to inform calculation of the threshold percentage requirement in this Compliance Indicator. The Process Document provided a detailed description of the licensing specialist's compliance determination following requirements in the *OL Annual Compliance Determination Chart ,* the data entry of the results into the CONNECT system, the query criteria to obtain the numeric data used to calculate the numerator and denominator, descriptions of the numerator and denominator for the equation, and the reporting processes to the RMRC on a quarterly and annual basis. The numerator and denominator descriptions are: | 22nd - Not Met<br><br>**23rd - Not Met** |

| Compliance Indicator | Facts | Analysis | Conclusion |
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| patterns and the use of baseline data to assess the effectiveness of risk management systems.<br><br>The licensing report will identify any identified areas of non-compliance with Licensing Regulations and associated recommendations. | harm in the events reported as well as the associated findings and recommendations.<br><br>The DBHDS Process Document: (*30.4, 30.5, 30.7 DOJ Process RM Requirements VER005*) provides detailed instructions for accurately and consistently calculating the percentage of providers who are meeting the requirements of this Compliance Indicator and the Attestation Statement: (*30.4, 30.5, 30.7 RM Requirements Attachment B – 8.30.2023*) documents testing and verification of the accuracy of the process and calculation methodology.<br><br>Data from licensing inspections conducted between 01/01/2023-06/30/2023 reflect that 98.4% of providers were assessed on all nine requirements under *§520.A.D.*<br><br>The Consultant's 23rd Period review of documentary evidence from a sample of 25 licensed providers inspected | **Numerator:** Total number of providers (licensed services) that were assessed for 100% of the 9 RM regulations during the reporting period<br>**Denominator:** Total number of providers (licensed services) that had an annual inspection during the reporting period.<br><br>The Process Document also included a description of the look-behind quality assurance process conducted by the OL Regional Manager (2 reviews per week) to ensure regulations are reviewed appropriately and the look-behind process conducted by the Quality Improvement Specialist (2 reviews per week) focusing on regulations §520, §620, and §160.E and follow-up provided to licensing specialists and Regional Managers regarding remedial action needed. Mitigation strategies for minor issues were also described. The Attestation Statement documented testing and verification of the data queries and calculation results for this measure with no noted errors. It also included verification of the mitigation strategy implementation outlined in the Process Document. This methodology accurately describes the numerator and denominator used to calculate the percentage threshold required by this Compliance Indicator. The *Annual Compliance Determination Chart-2023* now includes the nine elements of §520.A-D including the additional instructions for §520.C.5 and addresses all of the requirements of this Compliance Indicator.<br><br>Data from a CONNECT report (*30.4 520 Reviews 081623*) documenting licensing inspection findings relevant to *§520.A-D* reflect that 735/747 licensed providers (98.4%) inspected between 01/01/2023-06/30/2023 were assessed on all applicable requirements under *§520.A-D*. This is an increase of 4% above the CY2022 percentage.<br><br>While this percentage was above 98%, the consultant's review of documentary evidence from a sample of 25 licensed providers who had an annual licensing inspection between 01/01/2023-06/30/2023 found agreement with the licensing specialist's findings in only 13/25 (52%) sample providers specific to the requirements at *§520.C.5* and this Compliance Indicator.<br><br>DBHDS should create and implement an evaluation matrix to train its | |

| Compliance Indicator | Facts | Analysis | Conclusion |
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| | between 01/01/2023-06/30/2023 verified the accuracy of licensing specialist determinations of whether providers were meeting the requirements at *§520.C.5* in only 13/25 (52%) of the sample providers. This percentage was not sufficient for this reviewer to verify that licensing specialists are consistently following the instructions for determinations at *§520.C.5* as described in the *OL Annual Compliance Determination Chart-2023* and required by this Compliance Indicator. | licensing specialists in the specific focus areas related to appropriately responding to and addressing risk triggers and thresholds through the care concern process and provide intensive training to both providers and licensing specialists on the requirements included in this evaluation matrix.<br><br>The Commonwealth did not meet the requirements of this Indicator because this consultant's 23rd Period study could verify the accuracy of only 52% of the licensing specialists' determinations related to *§520.C.5.*<br>While this percentage agreement was an improvement over the 15% agreement from the sample review during the 22nd study, it is not sufficient to validate that licensing specialists are consistently and accurately assessing whether providers are meeting the regulatory requirements at *§520.C.5* and this Compliance Indicator. Based on concerns about the accuracy of licensing specialist determinations related to *§520.C.5*, there is insufficient evidence to support that the requirements of this Compliance Indicator have been achieved. | |
| **30.7:**<br>DBHDS monitors that providers appropriately respond to and address risk triggers and thresholds using Quality Service Reviews, or other methodology. Recommendations are issued to providers as needed, and system level findings and recommendations are used to update guidance and disseminated to providers. | DBHDS has established a requirement for inclusion of risk triggers and thresholds at *12VAC35-105-520.D* and has defined uniform risk triggers and thresholds as care concerns.<br><br>The RMRC continues to review data and information about care concerns in their meetings and at least annually determines if any changes to the list of care concerns are necessary based on review of care concern data over the previous year. | *12VAC35-105-520.D* requires that a provider's systemic risk assessment process shall incorporate uniform risk triggers and thresholds as defined by DBHDS. DBHDS has defined uniform risk triggers and thresholds as care concerns.<br><br>Pursuant to agreements in *Curative Action 30.7*, the current list of care concerns effective 01/2023 are:<br>• Multiple (2 or more) unplanned medical hospital admissions or ER visits for falls, choking, urinary tract infection, aspiration pneumonia, dehydration, or seizures within a ninety (90) day timeframe for any reason.<br>• Any incidents of a decubitus ulcer diagnosed by a medical professional, an increase in the severity level of a previously diagnosed decubitus ulcer, or a diagnosis of a bowel obstruction diagnosed by a medical professional.<br>• Any choking incident that requires physical aid by another person, such as abdominal thrusts (Heimlich maneuver), back blows, clearing of airway, or CPR.<br>• Multiple (2 or more) unplanned psychiatric admissions within a ninety (90) day timeframe for any reason. | 22nd - Met<br><br>**23rd - Met** |

| Compliance Indicator | Facts | Analysis | Conclusion |
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| | The RMRC and Region 5 Quality Council have continued their joint work on a QII related to care concerns that has produced tools and protocols to assist providers in their successful address of identified care concerns. Work to implement these tools has begun and is currently being evaluated to determine efficacy.<br><br>The DBHDS Incident Management Unit continues to review incidents reported through the CHRIS system and monitors the trends/pattern analysis reports in the CONNECT system that flag any incidents that meet the criteria as a care concern. They also assure notification of the provider, OIH and OHR regarding each identified care concern and assist in tracking the provider's response to the care concern once identified.<br><br>DBHDS, through the OL licensing inspection process, has processes in place to implement and monitor that | To address the elements of the Curative Action related to monitoring and data collection/review, following are the requirements that this reviewer verified are in place and operational:<br>• The DBHDS Incident Management Unit (IMU) reviews all serious incidents reported through the CHRIS system on a daily basis. The interface between CHRIS and the CONNECT system flags any incidents that meet the criteria as a care concern and notifies the provider, the Office of Integrated Health (OIH), and the Office of Human Rights (OHR). There are defined follow-up procedures that are initiated for each of these identified care concerns to assure full and complete address. Providers and DBHDS staff have access to historical reports in the CONNECT system related to each of these identified care concerns which can be used as source data for further trend/pattern analysis at the provider level. Licensing specialists also use the historical care concern reports when preparing for an annual inspection or investigation.<br>• The Office of Licensing (OL) continues to monitor providers address of care concerns through the annual licensing inspection process and any other licensing investigations being conducted. Details of this process are outlined in Compliance Indicator 30.4 above.<br>• DBHDS continues to provide training for providers and licensing specialists regarding care concern identification and follow-up processes pursuant to the regulations at §520.D including a 3-part comprehensive training entitled *"Minimizing Risk"* with an average of 900 participants in each of the sessions. In 06/2023, OL began providing an *"Initial Applicant Orientation"* webinar for new and prospective providers and a 3-part *"Licensed Provider Coaching Seminar"* for providers and licensing specialists. Each of these training opportunities includes address of the requirements *at §520.C-D* relating to care concerns.<br>• The RMRC and the Region 5 Regional Quality Council joined forces during FY23 to implement a Quality Improvement Initiative (QII) to address §520.D performance and that workgroup has continued its work through the present time. The *08/2023 RMRC Minutes* stated that the majority of the study has been completed and plans implemented. Current focus is on review of inspection reports to determine if providers are using the new tools and resources developed by the workgroup.<br>• OIH provides an annual report regarding care concerns to the RMRC. | |

| Compliance Indicator | Facts | Analysis | Conclusion |
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| | providers monitor incidents that occur to identify when risk triggers/care concerns, or other risks, are present.<br><br>The OIH provides a comprehensive report, *Developmental Disabilities Care Concerns FY23 Summary*, to the RMRC annually that provides data-based analysis of care concerns and follow-up actions to address individual concerns and trends/patterns identified through their ongoing analysis.<br><br>DBHDS continues to develop and deliver training for providers and licensing specialists that include specific focus areas related to appropriately responding to and addressing risk triggers and thresholds through the care concern process. | Their most recent report, *Developmental Disabilities Care Concerns FY23 Summary*, includes a thorough data-based trend/pattern analysis of care concern topics and information about provider responses when individual care concerns are identified to them. The report included identification of an increasing number of care concerns related to choking incidents, urinary tract infections, pressure injuries, and repeated falls and describes specific follow-up actions by OIH targeting these four areas and listing of provider trainings that addressed these topics more generally.<br><br>• In summary, DBHDS has continued and expanded its efforts to monitor that providers appropriately respond to and address risk triggers and thresholds (care concerns) through its Licensing functions, through work by the OIH and OHR, and through the oversight work of the RMRC. The automation of the care concern identification process in the CONNECT data system has further streamlined the care concern identification process and improved its accuracy and consistency. The DBHDS training initiatives have also continued and expanded since the conclusion of the 22nd study and the QII that focuses on the care concern process jointly sponsored by the RMRC and the Region 5 Quality Council is nearing completion of its work including implementation of additional tools and processes to better enable providers to identify and respond appropriately to care concerns. All of these efforts provide sufficient evidence that the Commonwealth has achieved and sustained achievement of the requirements of CI 30.7. | |
| **30.10:**<br>To enable them to adequately address harms and risks of harm, the Commonwealth requires that provider risk management systems | The Commonwealth did not meet the requirements of this CI because the CI 30.4 review of sample provider documents cannot confirm that DBHDS has sufficiently identified the need for | Previous reports confirmed that DBHDS has regulations in place that require provider risk management systems to report incidents of common risks and conditions faced by people with IDD that contribute to avoidable deaths (e.g., reportable incidents of choking, aspiration pneumonia, bowel obstruction, UTIs, decubitus ulcers) and that providers take prompt action when such events occur, or the risk is otherwise identified. The care concerns processes also address reporting and heightened monitoring of individual incidents of these | 22nd - Not Met<br><br>**23rd - Not Met** |

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| shall identify the incidence of common risks and conditions faced by people with IDD that contribute to avoidable deaths (e.g., reportable incidents of choking, aspiration pneumonia, bowel obstruction, UTIs, decubitus ulcers) and take prompt action when such events occur, or the risk is otherwise identified.<br><br>Corrective action plans are written and implemented for all providers, including CSBs, that do not meet standards.<br><br>If corrective actions do not have the intended effect, DBHDS takes further action pursuant to V.C.6. | corrective action plans to written and implemented for all providers, including CSBs, that do not meet standards.<br><br>Previous reports confirmed that DBHDS has regulations in place that require provider risk management systems to report incidents of common risks and conditions faced by people with IDD that contribute to avoidable deaths (e.g., reportable incidents of choking, aspiration pneumonia, bowel obstruction, UTIs, decubitus ulcers) and that providers take prompt action when such events occur, or the risk is otherwise identified. The care concerns processes also address reporting and heightened monitoring of individual incidents of these common risks and conditions. This study also continues to confirm that DBHDS has in place a triage and review system for serious incidents. If a provider is found not to have reported an incident involving one or more of these types of common risks and conditions that may | common risks and conditions. This 23rd Period study continues to confirm that DBHDS has in place a triage and review system for serious incidents. If a provider is found not to have reported an incident involving one or more of these types of common risks and conditions that may contribute to avoidable deaths, a CAP is required for non-compliance.<br><br>However, as previously noted, this CI requires that provider risk management systems identify the *incidence* of common risks and conditions faced by people with IDD that contribute to avoidable deaths (and take prompt action when such events occur, or the risk is otherwise identified. The term "incidence" refers to the rate of occurrence of a disease, injury or condition in a given population. In the past, while licensing specialists might have cited providers for not reporting individual incidents of these risks and conditions, they did not cite or require corrective action when providers failed to track and address the incidence of these risks and conditions across their entire populations.<br><br>DBHDS staff have previously reported that it was difficult to get provider-specific aggregate data from CHRIS, nor did they have the tools to facilitate the ability of providers to make an assessment of the incidence of common risks and conditions. In addition, as described at the time of the 22nd Period review, the existing licensing assessment processes did not include all required elements related to the provider's use of data at the individual and provider level to identify and address trends and patterns of harm and risk of harm in the events reported as well as the associated findings and recommendations. However, during the 22nd Period review, these elements were incorporated into the *OL Annual Compliance Determination Chart* and continue to be reflected there during the 23rd Period.<br><br>At the time of the 22nd Period review, DBHDS had also developed a three day provider training entitled *Minimizing Risk* to clarify expectations for providers and to facilitate the ability of DBHDS to assess these aspects of provider risk management programs more consistently. As a part of this initiative, DBHDS developed training and tools to assist providers to track categories of incidents that have been identified as having the potential to cause serious harm. Of particular note for the purposes of this CI, the tracking tools provided allowed | |

| Compliance Indicator | Facts | Analysis | Conclusion |
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| | contribute to avoidable deaths, a CAP is required for non-compliance.<br><br>As described above with regard to CI 30.4 and 30.7, during the 23rd Period, DBHDS implemented a three day provider training entitled *Minimizing Risk* to clarify expectations for providers and to facilitate the ability of DBHDS to assess these aspects of provider risk management programs more consistently. As a part of this initiative, DBHDS developed training and tools to assist providers to track categories of incidents that have been identified as having the potential to cause serious harm. Of particular note for the purposes of this CI, the tracking tools provided allowed for the tracking and aggregating of incident data in a manner that can be used to identify the incidence of common risks and conditions faced by people with IDD that contribute to avoidable deaths and disseminated the tools to all providers. | for the tracking and aggregating of incident data in a manner that can be used to identify the incidence of common risks and conditions faced by people with IDD that contribute to avoidable deaths (e.g., reportable incidents of choking, aspiration pneumonia, bowel obstruction, UTIs, decubitus ulcers). By tracking the types of incidents on an ongoing basis, the aggregated data is readily available and can be used to calculate incidence over time (i.e., trends) within a provider's service delivery system and to facilitate analysis and development of a meaningful and timely plan of action. DBHDS staff noted that providers are not required to use these specific tools, but must have such a functional process in place to meet the licensing requirements identified above.<br><br>As described above with regard to CI 30.4 and 30.7, during the 23rd Period, DBHDS implemented this training and disseminated the tools to all providers. In addition, on 8/27/23, DBHDS sent a memorandum to all providers of developmental disability services to inform them of these expectations. The memorandum specifically noted the expectations that, as a part of their quarterly reviews of serious incidents, providers are expected to conduct an analysis of trends, potential systemic issues or causes, indicated remediation, and documentation of steps taken to mitigate the potential for future incidents, and that DBHDS would update the licensing review protocols to be used by staff from the Office of Licensing to include the expectation under *12VAC35-105-160(C)* and *12VAC35-105-520(C)*.<br><br>However, as also described with regard to CI 30.4 above, the review of sample provider documents did not demonstrate that providers were currently using data at the individual and provider level, including data from incidents and investigations, to identify and address trends and patterns of harm and risk of harm in the events reported, as well as the associated findings and recommendations. Further, the consultant's review of documentary evidence from a sample of 25 licensed providers who had an annual licensing inspection between 01/01/23-06/30/23 found agreement with the licensing specialist's findings in only 13/25 (52%) sample providers specific to the requirements at *§520.C.5*. As a result, this study cannot confirm that DBHDS has sufficiently identified the need for corrective action plans to written and implemented for all providers, including CSBs, that do not meet standards. | |

| Compliance Indicator | Facts | Analysis | Conclusion |
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| | In addition, on 8/27/23, DBHDS sent a memorandum to all providers of developmental disability services to inform them of these expectations. The memorandum specifically noted the expectations that, as a part of their quarterly reviews of serious incidents, providers are expected to conduct an analysis of trends, potential systemic issues or causes, indicated remediation, and documentation of steps taken to mitigate the potential for future incidents, and that DBHDS would update the licensing review protocols to be used by staff from the Office of Licensing to include the expectation under *12VAC35-105-160(C)* and *12VAC35-105-520(C)*.<br><br>However, as also described with regard to CI 30.4 above, the review of sample provider documents did not demonstrate that providers were currently using data at the individual and provider level, including data from incidents and investigations, to identify and address trends | Therefore, the Commonwealth did not meet the requirements of this Indicator because the 23rd Period study could verify the accuracy of only 52% of the licensing specialists' determinations related to *§520.C.5.*<br><br>DBHDS should implement a training, monitoring, reporting and technical assistance initiative to ensure that providers identify the incidence of common risks and conditions faced by people with IDD that contribute to avoidable deaths. When providers do not take prompt action when such events occur, or the risk is otherwise identified, CAPs are written, implemented and tracked with DBHDS taking further actions, as warranted. | |

| Compliance Indicator | Facts | Analysis | Conclusion |
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| | and patterns of harm and risk of harm in the events reported, as well as the associated findings and recommendations. | | |
| **30.11:**<br>For each individual identified at high risk pursuant to Indicator #6 of V.B, the individual's provider shall develop a risk mitigation plan consistent with the indicators for III.C.5.b.1 that includes the individualized indicators of risk and actions to take to mitigate the risk when such indicators occur.<br><br>The provider shall implement the risk mitigation plan.<br><br>Corrective action plans are written and implemented for all providers, including CSBs, that do not meet standards.<br><br>If corrective actions do not have the intended effect, DBHDS takes | Overall, DBHDS fulfilled the requirements of this Indicator.<br><br>For this 23rd Period review, DBHDS continued to implement the procedures that met the requirements for CI 30.11 at the time of the 22nd Period review.<br><br>As described at the time of the 22nd Period review, DBHDS instituted a sufficient sample-based quality assurance methodology to measure whether reporting mechanisms were working appropriately to identify individuals at high risk pursuant to CI 29.19 (i.e., Indicator #6 of V.B). In addition, DBHDS had demonstrated it has effective licensing processes in place to monitor provider development and implementation of risk mitigation plans through the | For this 23rd Period review, DBHDS continued to implement the procedures that met the requirements for CI 30.11 at the time of the 22nd Period review. DBHDS again instituted a sufficient sample-based quality assurance methodology to measure whether reporting mechanisms were working appropriately to identify individuals at high risk pursuant to CI 29.19 (i.e., Indicator #6 of V.B).<br><br>DBHDS had also previously been able to extrapolate some findings to make population-level recommendations, which indicate that individuals in Tier 3, Levels 1-5 had a higher percentage of the risk of moving to Level 6 or 7. Since the group with the highest risk is likely to be substantially larger than the existing Level 6 or 7 population, this helped to alleviate previously reported concerns that the licensing process might under-sample the at-risk population. For the 23rd Period review, this methodology remained in effect.<br><br>At the time of the 22nd Period review, DBHDS had demonstrated overall that it had effective licensing processes in place to monitor provider development and implementation of risk mitigation plans through the licensing sample, and to issue and track implementation of related CAPs. This was evidenced by the finding of sustained achievement of the requirements for CI 30.5. While CI 30.4 was not met overall at that time, the pertinent licensing processes were determined to be sufficient for this purpose. For the 23rd Period review, the study found this continued to be the case.<br><br>As described at the time of the 22nd Period review, for the current period, the licensing review processes continued to be bolstered by supplemental monitoring efforts, as previously reported. These included the QSR process to evaluate the development and implementation of risk mitigation plans for a statistically significant sample of the overall population, which may include | 22nd - Met<br><br>**23rd - Met** |

| Compliance Indicator | Facts | Analysis | Conclusion |
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| further action pursuant to V.C.6.<br><br>. | licensing sample, and to issue and track implementation of related CAPs.<br><br>Overall, DBHDS has demonstrated it has effective licensing processes in place to monitor provider development and implementation of risk mitigation plans through the licensing sample, and to issue and track implementation of related CAPs. This was evidenced by the previous finding of sustained compliance for CI 30.5. While CI 30.4 was not met overall, the pertinent licensing processes were determined to be sufficient for this purpose.<br><br>For this 23rd Period review, DBHDS also added two more care concern thresholds for providers to monitor and held a three-part series on minimizing risk that addressed recommendations for identifying and managing risk and the individual and provider level and included provision of tools for tracking incidents and care concerns. DBHDS had also made | issuance of Quality Improvement Plans if noncompliance is found. In addition, the care concerns processes address monitoring, tracking and remediation of related risk identification and risk planning requirements for individuals on the DD waivers.<br><br>For this 23rd Period review, as described above with regard to CI 30.4, CI 30.7 and CI 30.10, it was positive that DBHDS added two more care concern thresholds for providers to monitor and held a three-part series on minimizing risk that addressed recommendations for identifying and managing risk and the individual and provider level and included provision of tools for tracking incidents and care concerns. DBHDS also reported making improvements to implementation of the RAT, and expanded the training and tools offered to providers to identify and mitigate risks, including incidents that meet the threshold for a care concern | |

| Compliance Indicator | Facts | Analysis | Conclusion |
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| | additional improvements to implementation of the RAT, and expanded the training and tools offered to providers to identify and mitigate risks, including incidents that meet the threshold for a care concern.<br><br>Also as previously reported, licensing review processes continued to be bolstered by supplemental monitoring efforts. | | |

## V.C.4 Analysis of 23rd 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 |
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| 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. | Overall, the Commonwealth met the requirements for this CI.<br><br>At the time of the 21st Period review, the OL had in place a sufficient processes for assessing compliance with *12VAC35-105-520*. These processes included a CAP requirement for providers cited for noncompliance to complete an approved training and complete an attestation form, 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. The provider did not need to submit the form to OL when completed, | At the time of the 21st Period review, the OL had in place a sufficient processes for assessing compliance with *12VAC35-105-520*. These processes included a CAP requirement for providers cited for noncompliance to complete an approved training and complete an attestation form, 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. The provider did not need to submit the form to OL when completed, but rather keep it on file to be presented when requested during onsite and remote inspections. For the 23rd Period review, the processes described above remained in effect. In addition, OL Licensing Specialists completed an ongoing look-behind review of the status of required attestations.<br><br>For this 23rd Period, DBHDS also provided evidence in the form of a spreadsheet for the period between 1/10/23 through 6/30/23, which showed 117 inspections for which the provider 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 and the requested evidence of CAP completion. The spreadsheet also showed completed CAPs (i.e., designated as "approved" for 100 (85%) of the inspections. In some cases, one CAP covered multiple inspections, so this analysis resulted in a total of 17 distinct providers that did not yet have an approved CAP. Based on interview with OL staff, 100% of the providers/inspections received a citation, as indicated by their presence on the spreadsheet, but the 17 that did not yet have approved status indicated only that they had not yet submitted a CAP that was acceptable and that it remained pending. For clarity, OL should consider using a spreadsheet similarly formatted to that provided for CI 32.4 below to include a "CAP Issued" column.<br><br>Despite the findings above, DBHDS also provided 93 completed attestations for this CI. Based on a crosswalk with the spreadsheet, the 93 attestations covered 100% of the distinct providers. | 21st - Met<br><br>**23rd - Met** |

| Compliance Indicator | Facts | Analysis | Conclusion |
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| | but rather keep it on file to be presented when requested during onsite and remote inspections.<br><br>For this 23rd Period, DBHDS provided a spreadsheet for this review showing providers that had received a citation for *520 A* and the status of the corrective action plan for each. | | |
| 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 | Overall, the Commonwealth met the requirements for this CI.<br><br>For this 23rd Period, as evidence of implementation of these processes, DBHDS provided a spreadsheet for a two quarter period from 1/1/23 through 6/30/23, showing 190 providers that had been determined to be non-compliant with requirements about training and expertise | Overall, the process analysis described with regard to CI 32.3 also applies to this CI.<br><br>For this 23rd Period, as evidence of implementation of these processes, DBHDS provided a spreadsheet for a two quarter period from 1/1/23 through 6/30/23, showing 138 distinct 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) 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)*. The spreadsheet also indicated whether OL had issued a CAP. For the 138 distinct providers, the spreadsheet showed that OL had issued a CAP for 136 (99%). However, DBHDS also provided a set of attestations for *160 C* and *160 E* that demonstrated completed CAPs for the two providers, so it appeared this was simply a data entry error.<br><br>Based on a crosswalk with the spreadsheet, DBHDS provided attestations for 131 of the 138 (95%) distinct providers. | 21st - Not Met<br><br>**23rd - Met** |

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| by the Commonwealth, or other training determined by the Commonwealth to be acceptable, as part of their corrective action plan process. | 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)*.<br><br>The spreadsheet also indicated whether OL had issued a CAP. For the 190 providers, the spreadsheet showed that OL had issued a CAP for 187 (98%). | | |
| 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 | RMRC used data and information from risk management activities, including mortality reviews to identify topics for future content.<br><br>The *Risk Management Program Description, FY24*, for the period from 7/1/23 through 6/30/24, states that, as part of the RMRC's task calendar, the | 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 23rd Period. The *Risk Management Program Description, FY24*, for the period from 7/1/23 through 6/30/24, states that, as part of the RMRC's task calendar, the RMRC reviews risks that have been identified as potential concerns and discusses the need to develop additional educational content to address these concerns. In addition, for this 23rd Period review, the RMRC reviews included serious incident data, as required by CI 29.13.<br><br>Consistent with the 21st Period report, based on review of the *Risk Management Program Description, FY24*, 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. The document states that if the RMRC determines that new or additional educational or informational material is needed, members make | 21st - Not Met<br><br>**23rd - Met** |

| Compliance Indicator | Facts | Analysis | Conclusion |
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| 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. | RMRC reviews risks that have been identified as potential concerns and discusses the need to develop additional educational content to address these concerns.<br><br>Based on review of the *Risk Management Program Description, FY24*, the RMRC procedures include review of surveillance data, PMIs, case reviews, care concerns 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.<br><br>The *Risk Management Program Description, FY24* also provided a description and examples of how DBHDS used risk management data and | 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 is expected to report back to the RMRC at least quarterly on progress.<br><br>This description of the process continued 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.)<br><br>With regard to the third criterion (i.e., identify providers that are in need of additional technical assistance or other corrective action), 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. The *Risk Management Program Description, FY24*, indicated DBHDS used risk management data and information for this purpose in the following ways:<br>• Identification may occur through review and follow-up on information presented to the RMRC, as well as from day-day activities occurring within program units.<br>• The RMRC may utilize information from ongoing data reporting to identify providers in need of assistance as part of an improvement activity. When the committee identifies a specific measure is not meeting its target, it may form a workgroup to conduct further analysis of the issue. If this analysis identifies that the issue is related to specific providers, as opposed to a system-wide issue, it may target intervention on those specific providers who are contributing to the performance issue. For example, as part of efforts to improve provider performance related to quality improvement programs, the RMRC worked with the Office of Licensing to identify specific providers that had not met the requirement to include measurable goals and objectives in their quality improvement plan. The Office of Clinical Quality Improvement then conducted outreach to these providers to offer technical assistance on | |

| Compliance Indicator | Facts | Analysis | Conclusion |
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| | information to identify providers that are in need of additional technical assistance or other corrective action.<br><br>For this 23rd Period review, DBHDS provided RMRC meeting minutes that demonstrated the implementation of these processes. Specifically, for this 23rd Period, minutes dated 3/20/23, 6/26/23 and 8/27/23 reflected related agenda items, discussions, presentations and action items.<br><br>In addition, as described throughout this document and at the time of the 21st Period review, DBHDS has continued to post substantial guidance for providers and others on its website related to risk management (e.g., the OIH and OL webpages). | developing measurable goals and objectives.<br>• Providers in need of technical assistance are also identified through the care concern process, with information on specific providers transmitted by the IMU to OIH to offer additional technical assistance. The OIH will follow-up with providers either via email or phone to offer technical assistance. Phone calls are made when the concern indicates a potential immediate threat to health and safety, for example, choking incidents. Assistance may be in the form of directing the provider to existing resources, such as written information or web-based or live training. It may also take the form of direct technical assistance, include case consultation and individualized training. In situations where concerns continue despite technical assistance, the provider may be referred to the OL to determine if any citations are warranted.<br>• The OL identifies providers that have specific deficiencies that are related to health and safety. Providers are required to develop corrective action plans to address the health and safety issue; the OL conducts follow-up within 30 days to ensure that the corrective actions have been implemented. If the corrective actions have not been implemented, the licensing specialist will continue to follow-up until they are. Providers that fail to implement corrective actions may receive progressive citations for this failure.<br>• Similarly, the Office of Human Rights (OHR) reviews all allegations of abuse and neglect, monitoring the provider's investigation, and offering technical assistance as necessary. When corrective actions are necessary, the human rights advocate follows up with the provider to ensure that these actions have been implemented.<br><br>For this 23rd Period review, DBHDS provided RMRC meeting minutes that demonstrated the implementation of these processes. Specifically, for this 23rd Period, minutes dated 3/20/23, 6/26/23 and 8/27/23 reflected related agenda items, discussions, presentations and action items. In addition, as described throughout this document and at the time of the 21st Period review, DBHDS has continued to post substantial guidance for providers and others on its website related to risk management (e.g., the OIH and OL webpages).<br><br>At the time of the 21st Period, the ability of DBHDS to implement similar procedures | |

| Compliance Indicator | Facts | Analysis | Conclusion |
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| | At the time of the 21st Period, the ability of DBHDS to implement similar procedures continued to be hampered to a significant degree by a lack of valid and reliable serious incident data. However, as described below for CI 36.1 and CI 38.1 with regard to data quality for the source systems, overall, for the 23rd Period, DBHDS has at least minimally implemented the requirements of the *Curative Action for Data Validity and Reliability*. | continued to be hampered to a significant degree by a lack of valid and reliable serious incident data. However, for the 23rd Period, overall, DBHDS has at least minimally implemented the requirements of the *Curative Action for Data Validity and Reliability*. This is described below for CI 36.1 and for CI 38.1 with regard to data quality for the source systems. | |

## V.D.1 Analysis of 23rd 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 |
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| 35.1: The Commonwealth implements the Quality Improvement Plan approved by CMS in the operation of its HCBS Waivers. | For this 23rd Period review, this CI was Not Met because the Commonwealth did not meet to review quarterly data or to develop and/or monitor needed remediation, as required in the Quality Improvement Systems (QIS) outlined in Appendix H for each of the HCBS Waivers.<br><br>Otherwise, DBHDS and DMAS had sufficiently addressed the deficiencies of the 21st Period review. This included the data validity and reliability deficiencies, as evidenced by findings | At the time of the 21st Period review, the Commonwealth was not fully implementing the requirements of the Quality Improvement Plan approved by CMS. The primary deficiency at that time included that the DBHDS data used for Waiver Performance Measures were not reliable and valid and could not be used to effectively prioritize quality improvement initiatives. In addition, DBHDS had not fully developed and implemented a data analysis and reporting methodology that measured the requirement for Performance Measure C.9 (i.e., number and percent of provider agency direct support professionals (DSPs) meeting competency training requirements).<br><br>For this 23rd Period review, DBHDS and DMAS had sufficiently addressed the data validity and reliability deficiencies, as evidenced by findings for CI 361. In addition, DBHDS reported that the calculations for two Performance Measures that address DSP training and competency (i.e., C8 and C9) now utilize DMAS QMR data, rather than from DBHDS processes.<br><br>However, as further described below for CI 35.5, the Quality Review Team (QRT) had not met during this 23rd Period to review quarterly data or to develop and/or monitor needed remediation. This requirement is outlined in the Quality Improvement Systems (QIS) outlined in Appendix H for each of the HCBS Waivers, which makes the following statement: "Following the end of each quarter, the QRT reviews data related to the waiver assurances. Representatives from various DBHDS and DMAS divisions and departments work collaboratively on the QRT to provide data, discuss barriers to compliance, and present remediation strategies to correct areas of deficiency."<br><br>Going forward, DMAS and DBHDS should ensure that they implement their stated | 21st - Not Met<br><br>**23rd - Not Met** |

| Compliance Indicator | Facts | Analysis | Conclusion |
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| | for CI 361.<br><br>In addition, DBHDS reported that the calculations for two Performance Measures that address DSP training and competency (i.e., C8 and C9) now utilize DMAS QMR data, rather than from DBHDS processes. | intent for the QRT to meet quarterly, as required, to review quarterly data or to develop and/or monitor needed remediation. | |
| 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 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 | For this 23rd Period review, this CI was Not Met because the DMAS and DBHDS did not meet to review quarterly data.<br><br>DBHDS reported that the QRT had undergone a transfer of ownership from DBHDS to DMAS and therefore no QRT meetings had occurred during this period of transition. The documentation further indicated the QRT planned to catch up on reviewing three quarters of data at a | For the 21st 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.) During the 23rd Period, DMAS received approval from CMS for renewals for each of the Waivers. While some modifications were made to Performance Measures in the approved renewal applications, the Waivers continued to include measures in each of the areas required for this CI.<br><br>The previous study documented that CI 36.1 of the Settlement Agreement requires that data sources will not be used for compliance reporting until they have been found to be valid and reliable. The Parties had agreed to a *Curative Action for Data Validity and Reliability* 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 required 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 CDO that the methodology in the Process Document is sufficient to produce valid and reliable data for the applicable performance measure or CI. However, at the time of the 21st Period review, DBHDS did not provide a Process Document and/or an Attestation for the applicable data sets used for specific waiver performance measures for which it was responsible for supplying the data. | 21st – Met*<br><br>**23rd – Not Met** |

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<tr><th>Compliance Indicator</th><th>Facts</th><th>Analysis</th><th>Conclusion</th></tr>
<tr>
<td>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>meeting scheduled for November 2023.<br><br>Otherwise, 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. through f.<br><br>DBHDS provided a Process Document and Data Set Attestation for the applicable data sets used for the specific Performance Measures with DBHDS data sources.<br><br>In addition, DMAS provided Process Documents and Attestations for DMAS data sources.<br><br>As described for CI 36.1 and for CI 38.1 below with regard to</td>
<td>For this 23rd Period, DBHDS provided a Process Document and applicable Data Set Attestation for each of ten measures that relied on DBHDS-collected data. The table below lists the established Performance Measures and the applicable Process Document for the data source for each of the measures for which DBHDS provides the Performance Measure data:<br><br>
<table>
<tr><th>Performance Measure</th><th>Process Document</th></tr>
<tr><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.</td><td>OHR Community Look-behind, dated 8/22/23</td></tr>
<tr><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)</td><td>G2 Abuse and Neglect Prevalence VER 002, dated 8/29/23</td></tr>
<tr><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.</td><td>Remediation of PP Deaths Process Document VER 003, dated 8/24/23</td></tr>
<tr><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.</td><td>LIC Asmt Incident Reprt Prov DS VER 005. Dated 8/23/23</td></tr>
<tr><td>Performance Measure G6. # and % of licensed DD providers that administer medications that were not cited for failure to review medication errors at least quarterly.</td><td>G6 Providers Review Medication Errors VER 002, dated 9/11/23</td></tr>
<tr><td>Performance Measure G7. Number and percent of individuals reviewed who did not have unauthorized restrictive interventions.</td><td>HR Process Document 29.25 VER 005, dated 6/20/23</td></tr>
<tr><td>Performance Measure G8. Number and percent of individuals who did not have unauthorized seclusion.</td><td>G8 Unauthorized Seclusion VER 002, dated 8/29/23</td></tr>
<tr><td>Performance Measure B1: Number and percent of all new enrollees who have a level of care evaluation prior to receiving waiver services</td><td>QRT DS B1 QRT VER 001, dated 9/1/23</td></tr>
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| Compliance Indicator | Facts | Analysis | Conclusion |
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| | data quality for the source systems, overall, DBHDS has at least minimally implemented the requirements of the *Curative Action for Data Validity and Reliability*. | | |

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| 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 | *B2 LOC Evaluation VER 002*, dated 9/5/23 |
| Performance Measure A3: Number and percent of slots allocated to CSB's in accordance with the standardized statewide slot assignment process | *A3 Slot Assignment VER 001*, dated 9/8/23 |

In addition, DBHDS provided the following Process Documents for the following data sets collected by DMAS:

- *Contract Evaluation VER003* (A1)
- *DBHDS Provider Memorandums VER001* (A2)
- *VIDES Choice Risk Assessments VER003* (B3, B4, D2, D12, D13)
- *Provider Enrollment VER003* (C1)
- *Criminal Record Check VER003* (C2, C5)
- *Provider CriteriaVER003* (C3, C4)
- *Consumer Directed Employees VER003* (C6, C7 )
- *Orientation and Competencies VER003* (C8, C9)
- *Service Facilitator Trng RequirementsVER003* (C10)
- *Plan Development VER003* (D1, D3, D4, D5, D6, D7, D8, D9, D10, D11)
- *Annual Notification of Rights VER001* (G4)

For each of the above Process Documents, DBHDS also submitted an applicable Data Set Attestation.

As described for CI 36.1 and for CI 38.1 below with regard to data quality for the source systems, overall, DBHDS has at least minimally implemented the requirements of the *Curative Action for Data Validity and Reliability*.

However, with regard to the requirement for a quarterly review of the performance measures, DBHDS reported that that the QRT had undergone a transfer of ownership from DBHDS to DMAS and therefore no QRT meetings occurred during this period of transition. The documentation further indicated the QRT planned to catch up on reviewing three quarters of data at a meeting scheduled for November 2023.

| Compliance Indicator | Facts | Analysis | Conclusion |
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| 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 | This CI was not met because DBHDS did not provide evidence of QRT meetings during which the members reviewed quarterly data or developed and/or monitored remediation plans.<br><br>Documentation indicated that the QRT had undergone a transfer of ownership from DBHDS to DMAS and therefore no QRT meetings had occurred during this period of transition. The documentation further indicated the QRT planned to catch up on reviewing three quarters of data at a meeting scheduled for November 2023.<br><br>The *SFY22 EOY Report* provided summaries for some measures that referenced possible | For this 23rd Period review, as reported above for CI 35.3, DBHDS did not provide evidence of QRT meetings which the members reviewed quarterly data, or developed and/or monitored remediation plans. Documentation indicated that the QRT had undergone a transfer of ownership from DBHDS to DMAS and therefore no QRT meetings had occurred during this period of transition. The documentation further indicated the QRT planned to catch up on reviewing three quarters of data at a meeting scheduled for November 2023.<br><br>At the time of the 21st Period review, there continued to be a need to develop improvement and remediation plans that evidenced a focus on systemic factors, both in QRT proceedings as well as in the *SFY21 EOY Report*. While that document provided summaries for some measures that referenced possible systemic remediation, they were not sufficient. The report narrative often did not include the specific strategy to be employed or define measures that would be used to monitor performance. In addition, it was impractical to use data that old for any comparative purposes to current year activities. For this 23rd Period review, as described further with regard to CI 35.7 below, the *SFY22 EOY Report*, which covered a period from 7/1/21 through 6/30/22, did not provide any information that addressed QRT fulfillment of the requirements of this CI for this 23rd Period. | 21st - Not Met<br><br>**23rd - Not Met** |

| Compliance Indicator | Facts | Analysis | Conclusion |
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| monitored | systemic remediation. However, the SFY 22 EOY Report, which covered a period from 7/1/21 through 6/30/22, did not provide any information that addressed QRT fulfillment of the requirements of this CI for this 23rd Period. | | |
| 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.<br><br>DBHDS previously 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 | Previous studies have found that *12VAC30-10-10* identified DMAS as the single state agency designated to administer or supervise the administration of the Medicaid program under Title XIX of the Social Security Act and described its authorities and responsibilities. For the 23rd Period, it appeared these citations and designation of responsibilities remained largely current and correct.<br><br>For the 21st Period review, DBHDS provided a document entitled *DMAS Provider Review Unit Policy Manual* that provided a detailed description of the annual audit plan and processes and demonstrated that DMAS conducted financial auditing consistent with the methods, scope and frequency of audits approved by CMS. This remained adequate for this 23rd Period. In addition, DBHDS submitted evidence that DMAS completed required financial reporting to CMS, per the 372 reports for each waiver, and the Financial Accountability Plans for each waiver, as found in the approved renewal applications, each dated 7/1/23.<br><br>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 | 21st - Met<br><br>**23rd - Met** |

| Compliance Indicator | Facts | Analysis | Conclusion |
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| | financial auditing consistent with the methods, scope and frequency of audits approved by CMS.<br><br>DBHDS submitted evidence that DMAS completed required financial reporting to CMS, per the 372 reports for each waiver, and the Financial Accountability Plans for each waiver, as found in the approved renewal applications, each dated 7/1/23.<br><br>For this 23rd Period, DBHDS reported that the calculations for two Performance Measures that address DSP training and competency (i.e., C8 and C9) now utilize DMAS QMR data, rather than from DBHDS processes. To ensure the Commonwealth collected data to accurately measure | 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 the 21st Period, 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.<br><br>For this 23rd Period, DBHDS reported that the calculations for two Performance Measures that address DSP training and competency (i.e., C8 and C9) now utilize DMAS QMR data, rather than from DBHDS processes. To ensure the Commonwealth collected data to accurately measure performance or identify and implement any needed remediation, as described with regard to CI 35.3 above, DBHDS submitted an applicable Process Document and Data Set Attestation. | |

| Compliance Indicator | Facts | Analysis | Conclusion |
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| | performance or identify and implement any needed remediation, as described with regard to CI 35.3 above, DBHDS submitted an applicable Process Document and Data Set Attestation. | | |
| 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 | For the 23rd period, the Commonwealth did not meet this CI because DBHDS did not provide evidence to show a local level or Community Service Boards (CSB) review, at least annually, of the Waiver Performance Measures.<br><br>For the 21st Period review, DBHDS provided an *SFY21 EOY Repor*t, revised as of August 2022 and covering the period 7/1/20 through 6/30/21. For the 23rd Period, DBHDS provided an *EOY Report*, revised as of | For the 21st Period review, DBHDS provided an *SFY21 EOY Report*, revised as of August 2022 and covering the period 7/1/20 through 6/30/21. For the 23rd Period, DBHDS provided an *SFY22 EOY Report*, revised as of 9/20/23, and covering the period 7/1/21 through 6/30/22. This met the standard for being completed on an annual basis.<br><br>However, as reported previously, 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 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 during the 21st 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 FY 2024 QRT charter added a requirement that, going forward, the QRT shall produce the *EOY Report* for the public review within no more than 6 months of the end of the preceding fiscal year. However, for this 23rd Period review, this had not yet occurred<br><br>The remaining requirements for CI 35.7 focus on local level and CSB reviews of EOY reports, at least annually. Previous reports described a process whereby DBHDS submitted the annual *EOY Report* to CSBs for review using a targeted *Survey Monkey* questionnaire. During the 21st Period review, the DBHDS QRT Manager reported receiving responses to the survey for the previous *EOY Report* from 38 of 40 CSBs. | 21st - Not Met<br><br>**23rd - Not Met** |

| Compliance Indicator | Facts | Analysis | Conclusion |
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| (CSB) at least annually. | 9/20/23 and covering the period 7/1/21 through 6/30/22. This met the standard for being completed on an annual basis.<br><br>However, as reported previously, the *EOY Report* data were again more than 14 months old and therefore were not adequate or useful for CSB quality improvement committees to establish CSB-specific quality improvement activities. The FY 2024 QRT charter added a requirement that, going forward, the QRT shall produce the *EOY Report* for the public review within no more than 6 months of end of the preceding fiscal year. However, for this 23rd Period review, this had not yet occurred. | However, for this 23rd Period review, DBHDS did not provide any evidence to show the CSB reviews occurred. | |

| Compliance Indicator | Facts | Analysis | Conclusion |
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| 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. | For the 23rd period, the Commonwealth did not meet this CI because the most recently reported data showed performance at only 83%.<br><br>The *Case Management Steering Committee Semi-Annual Reports State Fiscal Year 2023 3rd and 4th Quarters*, dated 9/8/23, indicated that, in FY22, performance dropped to 83%, below the target. It further stated that joint efforts with DMAS occurred in FY23 to initiate services with individuals following the national public health emergency ends. Those FY23 data will be reported at the time of the next semi-annual report.<br><br>DBHDS submitted an applicable Process Document, entitled *DD CMSC VER 016*, dated 8/29/23, and | For the 23rd Period review, DBHDS provided the *Case Management Steering Committee Semi-Annual Reports State Fiscal Year 2023 3rd and 4th Quarters*, dated 9/8/23. The report indicated that, in FY23, performance dropped to 83%, below the target. It further stated that joint efforts with DMAS occurred in FY23 to initiate services with individuals following the national public health emergency ends. Those FY23 data will be reported at the time of the next semi-annual report. This study had previously recommended that 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 decreasing performance over time. This continues to be necessary. With the quarterly results, DBHDS, DMAS and the CMSC should identify potentially concerning performance trends and take remedial actions on a more timely basis.<br><br>DBHDS submitted an applicable Process Document, entitled *DD CMSC VER 016*, dated 8/29/23, and an applicable Data Set Attestation, dated 8/30/23. These met the requirements for the *Curative Action for Data Validity and Reliability*. | 21st - Met*<br><br>**23rd - Not Met** |

| Compliance Indicator | Facts | Analysis | Conclusion |
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| | an applicable Data Set Attestation, dated 8/30/23. These met the requirements for the *Curative Action for Data Validity and Reliability*. | | |

## V.D.2 Analysis of 23rd 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 |
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| 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 | Overall, DBHDS at least minimally fulfilled the requirements of this Indicator.<br><br>For this 23rd Period, DBHDS issued the *Data Quality Monitoring Plan Source System Report,* dated 9/28/23. This is the annual update produced using the methodology described in the *Data Quality Monitoring Plan: Annual Update Process,* dated April 2021.<br><br>In addition to a chart of source systems, the *Data Quality Monitoring* | Previous studies have documented the steps DBHDS has 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*.) During the 19th Period review, DBHDS acknowledged that it had not yet addressed the recommendations from the original version in a comprehensive manner, but 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.<br><br>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 | 21st - Not Met<br><br>**23rd - Met** |

| Compliance Indicator | Facts | Analysis | Conclusion |
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| uniqueness. | *Plan Source System Report* included, for 16 source systems, a narrative description of the improvements DBHDS indicated staff had made.<br><br>With regard to the QSR data source system, DBHDS finalized the most recent version of the *External Data Validation Checklist* on 3/1/23. While this did not fully address the previously identified concerns, this study determined that, in its finished state, it at least minimally met the requirements of the *Curative Action for Data Validity and Reliability*. However, the study found some remaining concerns that DBHDS should address going forward. Chief among these was the failure of the assessment to address potential IRR | 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. It includes two elements:<br>• The first requires DBHDS to continue to complete periodic assessments of its data source systems, including the identification of threats to data validity and reliability and actions taken to mitigate those threats.<br>• The second 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 OCQM, that office is responsible for identifying the threats to data validity and reliability in the data collection methodologies. The *Curative Action for Data Validity and Reliability* describes creation of a Process Document that, among other things, for each applicable purpose 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 Chief Data Office (CDO) completes a review and attests that the process will produce valid and reliable data. This is known as the Data Set Attestation.<br><br>**Source System Assessment:** For this 23rd Period, DBHDS issued the *Data Quality Monitoring Plan Source System Report,* dated 9/28/23. This is the annual update produced using the methodology described in the *Data Quality Monitoring Plan: Annual Update Process,* described above. In addition to a chart of source systems, as replicated below, it included, for 16 source systems, a narrative description of the improvements DBHDS indicated staff had made in the following categories: Data Validation Controls, Key Documentation, Manual Data Processing, User Interface, and Backend Structure. The source systems reviewed during the period include the following:<br>1. Avatar<br>2. Children in Nursing Facilities Spreadsheet<br>3. CHRIS- Serious Incident Report (SIR)<br>4. CHRIS-Human Rights (HR)<br>5. Community Consumer Submission 3 (CCS3) | |

| Compliance Indicator | Facts | Analysis | Conclusion |
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| | deficiencies and their impact on data validity and reliability. Previous Reports to the Court have repeatedly identified these concerns and provided multiple examples of discrepancies between the data findings of the QSR reviewers and those of the Independent Reviewer's consultants.<br><br>For this 23rd Period review, DBHDS had made significant strides in implementation of the requirements of *Curative Action for Data Validity and Reliability* and consistently provided more comprehensive Process Documents and Data Set Attestations that addressed identified threats to validity and reliability and the | 6. CONNECT<br>7. Consolidated Employment Spreadsheet<br>8. Protection and Advocacy Incident Reporting System (PAIRS)<br>9. Quality Service Review (QSR)<br>10. Regional Educational Assessment Crisis Habilitation (REACH)<br>11. Support Coordination Quality Review (SCQR)<br>12. Waiver Management System (WaMS) Individual Support Plan (ISP) Proper<br>13. WaMS Customized Rate Module<br>14. WaMS Individual and Family Support Program (IFSP) Module<br>15. WaMS Regional Support Team (RST) Module<br>16. WaMS Waitlist Module<br><br>This most recent version of the *Data Quality Monitoring Plan Source System Report* summarizes areas of improvement identified during the past year. Of note, several systems continued to be slated for replacement, including AVATAR, CHRIS-SIR, CHRIS-HR, CCC-3 and PAIRS. As previously reported, DBHDS planned to replace these three systems with a unified Incident Management system, but had not yet released a Request for Proposals (RFP) for that system.<br><br>At the time of the previous review, DBHDS had not completed an evaluation of the QSR source system to establish that the data were valid and reliable. Instead, the *DBHDS Response to DQMP Recommendations* noted that DBHDS and QSR Contractor staff completed an *External Data Validation Checklist*. At that time, the study found this could not take the place of a source system assessment, as required by the Curative Action. Among the limitations of the checklist was that there was no way to validate whether the checklist is an objective measure of the validity and reliability of external data sources because none of the items were independently validated using objective standards. In addition, DBHDS had yet to devise a scoring system for the checklist, and did 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. In addition, procedurally, DBHDS had not finalized the *External Data Validation Checklist*.<br><br>For this 23rd Period, DBHDS finalized the most recent version of the *External Data Validation Checklist* on 3/1/23. While this did not fully address the previously identified concerns, this study determined that, in its finished state, the document at least | |

| Compliance Indicator | Facts | Analysis | Conclusion |
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| | adequacy of mitigation strategies.<br><br>However, similarly to the findings for the QSR source system assessment, the study recommends that DBHDS should further examine the Process Documents and Data Set Attestations for QSR data sets to ensure the IRR threats have been adequately identified and addressed. With that caveat, it still appeared that DBHDS had at least minimally met this element. | minimally met the requirements of the *Curative Action for Data Validity and Reliability*. However, the study found some remaining concerns that DBHDS should address going forward. Chief among these was the failure of the assessment to address potential IRR deficiencies and their impact on data validity and reliability. Previous Reports to the Court have repeatedly identified these concerns and provided multiple examples of discrepancies between the data findings of the QSR reviewers and those of the Independent Reviewer's consultants.<br><br>**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 OCQM, that office is responsible for identifying the threats to data validity and reliability in the data collection methodologies. The Curative Action describes creation of a Process Document that, among other things, for each applicable purpose 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 Chief Data Office (CDO) completes a review and attests that the process will produce valid and reliable data. This is known as the Data Set Attestation.<br><br>At the time of the 21st Period review, based on a review of the available Process Documents and Data Set Attestations, DBHDS could not yet reliably attest to the use of many of the applicable data sets for the PMIs, QIIs or CI metrics. While improvement was noted during the 22nd Period review, concerns remained. For this 23rd Period review, DBHDS had made significant strides in implementation of the requirements of *Curative Action for Data Validity and Reliability* and consistently provided more comprehensive Process Documents and Data Set Attestations that addressed identified threats to validity and reliability and the adequacy of mitigation strategies.<br><br>However, similarly to the findings for the QSR source system assessment, the study recommends that DBHDS should further examine the Process Documents and Data Set Attestations for QSR data sets to ensure the IRR threats have been adequately identified and addressed. With that caveat, it still appeared that DBHDS had at least minimally met this element. | |

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| 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. | Overall, DBHDS fulfilled the requirements of this Indicator.<br><br>For the 23rd Period, 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.<br><br>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 | For the 23rd Period, 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. 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.<br><br>As described above for CI 36.1 and for CI 38.1 below with regard to data quality for the source systems, overall, DBHDS has at least minimally implemented the requirements of the Curative Action for Data Validity and Reliability. | 21st - Met*<br><br>**23rd - Met** |

| Compliance Indicator | Facts | Analysis | Conclusion |
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| | enhanced outreach and information.<br><br>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.<br><br>As described above for CI 36.1 and for CI 38.1 below with regard to data quality for the source systems, overall, DBHDS has at least minimally implemented the requirements of the *Curative Action for Data Validity and Reliability*. | | |
| 36.3 At least annually, DBHDS reviews data from the Quality Service Reviews and National Core Indicators related to the quality of services and | Overall, DBHDS fulfilled the requirements of this Indicator. DBHDS had a process in place to review and analyze | For this 23rd Period review, DBHDS had a process in place to review and analyze the NCI and QSR results for meaningful quality improvement.<br><br>**NCI:** At the time of the 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 | 21st - Not Met<br><br>**23rd - Met** |

| Compliance Indicator | Facts | Analysis | Conclusion |
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| 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. | the NCI and QSR results for meaningful quality improvement.<br><br>For this 23rd Period review, based on a review of QIC minutes for four quarters (i.e., SFY23 Q2 and Q4 and SFY24 Q1 and Q2), the QIC reviewed NCI data and discussed quality of services and individual level outcomes on 3/27/23, and assigned subcommittees to review recommendations and report back to the QIC. In addition, at the QIC meeting on 6/26/23, the minutes reflected that the RQCs, RMRC, CMSC and KPA Workgroups each provided NCI-specific feedback.<br><br>For the 23rd Period review, the QIC | potential service gaps or issues with the accessibility of services. For this 23rd Period review, as described above with regard to CI 29.8, these processes continued to be in place.<br><br>At the time of the 21st Period review, a review of QIC presentations and minutes did not document that the QIC met the requirements of this indicator by reviewing NCI data or making strategic improvement recommendations. For this 23rd Period review, based on a review of QIC minutes for four quarters (i.e., SFY23 Q2 and Q4 and SFY24 Q1 and Q2), the QIC reviewed NCI data and discussed quality of services and individual level outcomes on 3/27/23, and assigned subcommittees to review recommendations and report back to the QIC. In addition, at the QIC meeting on 6/26/23, the minutes reflected that the RQCs, RMRC, CMSC and KPA Workgroups each provided NCI-specific feedback. RQC 2 and RQC5 also both recommended that DBHDS create a focus group involving OIH, OHR, VCU and other interested parties to perform a deeper dive into the Virginia NCI data relating to mental health medications.<br><br>**QSR:** For the 23rd Period review, the QIC minutes cited above showed that the QIC reviewed and discussed QSR data for all four quarters. Similarly to the review of recommendations for NCI described above, at the QIC meeting on 6/26/23, RQCs, RMRC, CMSC and KPA Workgroups each provided QSR-specific feedback. The RQCs (RQC 1 and RCQ 2) and the KPA Workgroups each identified QII opportunities related to the data. The RMRC and CMSC linked the data to current and proposed QIIs as well.<br><br>As described above for CI 36.1 and for CI 38.1 below with regard to data quality for the source systems, overall, DBHDS has at least minimally implemented the requirements of the *Curative Action for Data Validity and Reliability*. | |

| Compliance Indicator | Facts | Analysis | Conclusion |
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| | minutes cited above showed that the QIC reviewed and discussed QSR data for all four quarters. Similarly to the review of recommendations for NCI described above, at the QIC meeting on 6/26/23, RQCs, RMRC, CMSC and KPA Workgroups each provided QSR-specific feedback.<br><br>As described above for CI 36.1 and for CI 38.1 below with regard to data quality for the source systems, overall, DBHDS has at least minimally implemented the requirements of the *Curative Action for Data Validity and Reliability*. | | |

<table>
<tr><th>Compliance Indicator</th><th>Facts</th><th>Analysis</th><th>Conclusion</th></tr>
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<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 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,</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<br><br>DBHDS generally correctly categorized the PMIs as either outcomes or outputs.<br><br>As described above for CI 36.1 and for CI 38.1 below with regard to data quality for the source systems, overall, DBHDS has at least minimally implemented the requirements of the Curative Action for Data Validity and Reliability.</td>
<td>For previous reviews, 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 23rd Period review, this document remained current.<br><br>For the 23rd Period, the RMRC, CMSC, KPA workgroups and MRC all established goals and monitored progress towards achievement through the creation of specific KPA Performance Measure Indicators (PMI). DBHDS provided documentation indicating it currently had PMIs for all domains across the three Key Performance Areas (KPAs): Health, Safety and Well-being, Community Inclusion and Provider Competency and Capacity. The table below show each of these measures, organized by domain. This included two new measures, as indicated in the table. The CMSC discontinued two previous measures [i.e., 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, and Regional Support Team (RST) non-emergency referrals are made in sufficient time for the RSTs to meet and attempt to resolve identified barriers], but continued to track them as surveillance measures.
<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 63.24 or less</td></tr>
<tr><td>Safety and Freedom from Harm</td><td>KPA Workgroups</td><td>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</td></tr>
</table>
</td>
<td>21st - Met*<br><br>23rd - Met</td>
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| Compliance Indicator | Facts | Analysis | | | | Conclusion |
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| annual medical exams, timely and complete investigations of allegations of abuse). | | | | | plans. | |
| | | | Safety and Freedom from Harm | MRC | Unexpected deaths where the cause of death, or a factor in the death, was potentially preventable and some intervention to remediate was taken. **(New)** | |
| | | | 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. | |

| Compliance Indicator | Facts | Analysis | | | | | Conclusion |
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| | | | 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. | | |
| | | | 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. | | |

| Compliance Indicator | Facts | Analysis | | | | Conclusion |
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| | | | Community Inclusion | KPA Workgroups | 86% of providers demonstrate a commitment to community inclusion by demonstrating actions that lead to participation in community integration activities (Using the QSRs, providers report on number who promote meaningful work, promote individuals participating in non-large group activities, and encourages participation in community outings with people other than those with whom they live.) **(New)** | |
| | | | Provider Capacity | RMRC | Critical incidents are reported to the Office of Licensing within the required timeframe (24 hours). | |
| | | | 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. | |

| Compliance Indicator | Facts | Analysis | Conclusion |
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| 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. |

At the time of the 21st Period review, in most instances, it appeared DBHDS staff had frequently applied a correct outcome or output designation to each of the PMIs, despite some CMSC measures that appeared to have been incorrectly designated as outcomes. For the 23rd Period, all but one PMI appeared to have been correctly designated. The exception was the PMI that read, "86% of providers demonstrate a commitment to community inclusion by demonstrating actions that lead to participation in community integration activities." While one would hope this would lead to improved integration outcomes for individuals, this PMI measures provider actions and commitment, rather than improved integration outcomes for individuals. This did not impact overall compliance.

As described above for CI 36.1 and for CI 38.1 below with regard to data quality for the source systems, overall, DBHDS has at least minimally implemented the requirements of the *Curative Action for Data Validity and Reliability*.

| Compliance Indicator | Facts | Analysis | Conclusion |
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| 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. | Overall, DBHDS fulfilled the requirements of this Indicator.<br><br>For this 23rd Period review, DBHDS had begun using the Process Document template for documenting the methodologies for all PMIs and no longer used the PMI template. Overall, the Process Document template addressed each of the requirements of 36.5. | For this 23rd Period review, DBHDS no longer used the PMI template, but had begun using the Process Document template for documenting the methodologies for all PMIs.<br><br>Overall, the Process Document template addressed each of the requirements of 36.5, including: 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. | 21st - Met<br><br>**23rd - Met** |

| Compliance Indicator | Facts | Analysis | Conclusion |
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| 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. | Overall, DBHDS fulfilled the requirements of this Indicator.<br><br>DBHDS was using a system for tracking PMIs as described in the *Developmental Disabilities Quality Management Plan State Fiscal Year 2024*, dated 9/13/23.<br><br>The plan and the OCQM *Quality Committees Policy & Procedure*, effective 2/9/22, include procedures to track the efficacy of preventative, corrective, and improvement measures, and through its various committees and workgroups, including but not limited to the QIC, to develop and implement preventative, corrective, and improvement | DBHDS was using a system for tracking PMIs as described in the *Developmental Disabilities Quality Management Plan State Fiscal Year 2024*, dated 9/13/23. The plan and the OCQM *Quality Committees Policy & Procedure*, effective 2/9/22, include procedures to track the efficacy of preventative, corrective, and improvement measures, and through its various committees and workgroups, including but not limited to the QIC, to develop and implement preventative, corrective, and improvement measures where PMIs indicated health and safety concerns. 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.<br><br>As described above for CI 36.1 and for CI 38.1 below with regard to data quality for the source systems, overall, DBHDS has at least minimally implemented the requirements of the *Curative Action for Data Validity and Reliability*. | 21st - Met*<br><br>**23rd - Met** |

| Compliance Indicator | Facts | Analysis | Conclusion |
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| | measures where PMIs indicated health and safety concerns.<br><br>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.<br><br>As described above for CI 36.1 and for CI 38.1 with regard to data quality for the source systems, overall, DBHDS has at least minimally implemented the requirements of the *Curative Action for Data Validity and Reliability*. | | |

| Compliance Indicator | Facts | Analysis | Conclusion |
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| 36.7: DBHDS demonstrates annually at least 3 ways in which it has utilized data collection and analysis to enhance outreach, education, or training. | Overall, DBHDS fulfilled the requirements of this Indicator.<br><br>For this 23rd Period review, at the QIC meetings for the first and second quarters of SFY 224, DBHDS subcommittees and workgroups offered PowerPoint presentations that described ways in which they used data collection and analysis to enhance outreach, education, or training.<br><br>With regard to data validity and reliability, as described above for CI 36.1 and for CI 38.1 below with regard to data quality for the source systems, overall, DBHDS has at least minimally implemented the requirements of the | For this 23rd Period review, at the QIC meetings for the SFY23 Q4 and SFY24 Q1, each DBHDS subcommittee and workgroup again offered PowerPoint presentations that described ways in which they used data collection and analysis to enhance outreach, education, or training.<br><br>Examples from SFY24 Q1 presentations included the following:<br>• The RMRC reported the following examples:<br>o RMRC partnered with the Office of Licensing / Incident Management Unit to develop a one page explanation of Risk Triggers and Thresholds, as well as Care Concerns, as these were found through the QII, to be a point of confusion.<br>o RMRC partnered with the OIH and others to develop the Excel Risk Tracker, a tool that providers can use to track and graph the number of serious incidents, examine trends and conduct quarterly and annual reviews.<br>o RMRC, as part of the *520CD* QII, partnered with the OL to develop and implement a three part series entitled 'Minimizing Risk' which was designed to address barriers to providers' meeting the licensing regulations 160C, 520C and 520D and beyond. RMRC also provided input to the Systemic Risk Assessment Template , developed by the OL, which was introduced and distributed as part of the Minimizing Risk training.<br>• The CMSC reported the following examples:<br>o Data continues to be shared with CSBs monthly and quarterly.<br>o A Data Quality Support Dashboard has been in development for use with CSB meetings focusing on CM contact data reliability and validity, which will be implemented in the coming quarter<br>o The CMSC reports are provided through MS Teams, which gives CSBs access to review all measures and activities of the committee.<br>• The MRC reported the following examples:<br>o Office of Integrated Health Network Supports (OIHNS) provided training on nutrition and dysphagia in the fall of SFY23.<br>o OIHNS provided a 3 part training on Emergency Management in the winter/spring of SFY23<br>o The Annual Healthcare Visit Toolkit was posted in July 2023 to the | 21st - Met*<br><br>**23rd - Met** |

| Compliance Indicator | Facts | Analysis | Conclusion |
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| | *Curative Action for Data Validity and Reliability*. | OIHNS website<br><br>With regard to data validity and reliability, as described above for CI 36.1 and for CI 38.1 below with regard to data quality for the source systems, overall, DBHDS has at least minimally implemented the requirements of the *Curative Action for Data Validity and Reliability*. | |
| 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. | The Commonwealth did not meet the requirements of CI 36.8 because DBHDS made several potentially significant modifications to the previously proposed methodology that not only could impact the validity of the sample, but this methodology does not appear to fulfill the corrective action requirements of the CI. DBHDS made this information available with only one month remaining in the 23rd Period, so there was not sufficient time for the Independent Reviewer to investigate and verify the data quality.<br><br>A future study would | At the time of the 21st Period review, based on review of a Process Document entitled *Identification and Monitoring of Complex Behavioral, Health and Adaptive Support Needs*, DBHDS had made progress toward developing the capacity to report this measure, but it had not yet been implemented. Based on a review of the methodology proposed at that time, it appeared that if implemented as written, it would be sufficient to meet the requirements of this CI. For this 23rd Period review, in late August 2023, (i.e., during the fifth month of the sixth month long 23rd Period), DBHDS made available certain results of data collection for this CI. However, the documentation noted that, for this data collection, DBHDS had made several potentially significant modifications to the previously proposed methodology. These modifications could impact the validity of the sample and did not appear to fully address the corrective action requirements of the CI. With only one month remaining in the 23rd Period, there was not sufficient time for the Independent Reviewer to investigate and verify the data quality<br><br>The steps previously outlined in the document reflected a multi-disciplinary sampling approach, including review of the ISP, RAT and Crisis Risk Assessment tool review by the DBHDS OIH Registered Nurse Care Consultant (RNCC) reviewers and the Office of Crisis Services for behavioral support needs, and an On-Site Visit Tool (OSVT) review by the Office Of Provider Development staff. For this 23rd Period review, the process described in the *Complex Needs Review V.D.2 36.8*, dated August 2023, and in the accompanying Process Document entitled *36.08 Complex Needs Review*, dated 8/23/23, was completed solely by the OIH RNCC. It was not stated in either of these documents why DBHDS moved away from the previously described multi-disciplinary methodology or whether DBHDS considered any potential inter-rater ramifications.<br><br>In addition, at the time of the 21st Period, the methodology stated that the Office of EHA or the Waiver Access Management System (WaMS) Senior Data Analyst staff would 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 would be stratified across | 21st - Not Met<br><br>**23rd - Not Met** |

| Compliance Indicator | Facts | Analysis | Conclusion |
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| | be required to determine whether this methodology is sufficient to confirm the new methodology is sufficient to achieve the requirements of this indicator.<br><br>For this 23rd Period review, DBHDS submitted a summary document entitled *Complex Needs Review V.D.2 36.8*, dated August 2023, a Process Document entitled *36.08 Complex Needs Review*, dated 8/23/23. DBHDS did not submit a Data Set Attestations for this CI. Instead DBHDS submitted Process Documents and Attestations for several other data sets to be reviewed in this process, but these did not typically address the use of the data set for this CI.<br><br>For this 23rd Period, the Process | CSBs and ensure that the number of individuals reviewed per CSB reflects the number of individuals the CSB serves. For this 23rd Period, the Process Document stated that the sampling procedure in step 1 is the same as for CI 29.19, which calls for the Commonwealth to require providers to identify individuals who are at high risk due to medical or behavioral needs or other factors that lead to a SIS level 6 or 7 and to report this information to the Commonwealth. However, that resulting number might not be large enough for CI 36.8. In and of itself, the 29.19 sampling procedure does not focus on known individuals with identified complex behavioral, health and adaptive support needs. Rather, it seeks to identify such individuals from within a larger population across all SIS levels. Therefore, it is not clear this sampling procedure would yield a statistically valid sample for the purposes of CI 36.8. The Process Document does not address this requirement.<br><br>The CI requires that DBHDS develop 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. At the time of the 21st Period review, the proposed methodology indicated that the Case Management Steering Committee chair (or designee) would 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 was to be completed via correspondence with the CSB and documented accordingly.<br><br>For this 23rd Period review, the methodology discusses a process for "follow-up" that falls short of what is required for a corrective action: a corrective action includes action step(s) to be completed to achieve a verifiable outcome(s) by a specific date(s). It is not clear whether a step for the reviewer to look back at ISPs that were marked for additional follow-up needed at the previous review would be sufficient if the outcome of the corrective action is not verifiable and does not include an expected completion date. Even then, the methodology requires that if follow-up recommendations from the previous review were not completed, the reviewer is only instructed to reach out to the Support Coordinator to determine reasons for not implementing the recommendations and "additional information." In other words, the methodology does not clearly include requirements to identify objective corrective actions for all deficiencies or for the closure of the loop to ensure timely completion of such corrective actions. | |

| Compliance Indicator | Facts | Analysis | Conclusion |
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| | Document stated that the sampling procedure in step 1 is the same as for CI 29.19, which calls for the Commonwealth to require providers to identify individuals who are at high risk due to medical or behavioral needs or other factors that lead to a SIS level 6 or 7 and to report this information to the Commonwealth. However, that resulting number might not be large enough for CI 36.8. In and of itself, the 29.19 sampling procedure does not focus on known individuals with identified complex behavioral, health and adaptive support needs. Rather, it seeks to identify such individuals from within a larger population across all SIS levels. Therefore, it is not clear this | DBHDS did not submit a Data Set Attestations for this CI. Instead DBHDS submitted Process Documents and Attestations for several other data sets that would be reviewed in this process, but these did not typically address the use of the data set for this CI.<br><br>DBHDS should implement a review to determine whether its new methodology is sufficient to achieve the requirements of this indicator, including that 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. DBHDS should submit Process Documents and Attestations for all data sets to be reviewed in this process including those that address the use of the data set for this CI. The number of individuals reviewed must be large enough for a statistically significant sample.<br><br>A future Independent Reviewer's study would be required to determine whether this methodology is sufficient to confirm that the new methodology is sufficient to achieve the requirements of this indicator. | |

| Compliance Indicator | Facts | Analysis | Conclusion |
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| | sampling procedure would yield a statistically valid sample for the purposes of CI 36.8. The Process Document does not address this requirement.<br><br>The CI requires that DBHDS develop corrective action(s) based on its analysis, tracks the efficacy of that action, and revises as necessary to ensure that the action addresses the deficiency. For the previous review, the proposed methodology required the case Management Steering Committee chair or designee to define the corrective action steps that were needed with an objective metric (SMART objective), provide due date(s), and monitor any steps to completion | | |

| Compliance Indicator | Facts | Analysis | Conclusion |
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| | for any CSB found to be deficient.<br><br>For the 23rd Period, the methodology does not involve the Case Management Steering Committee chair (or designee) or require specific corrective action steps that are needed with an objective metric. It does not specify due dates and does not require monitoring of steps for completion, but rather indicates the reviewer should look back at ISPs that were marked for additional follow-up needed at the previous review. Even then, if recommendations were not completed, the reviewer is only instructed to reach out to the Support Coordinator to determine reasons for not implementing the recommendations | | |

| Compliance Indicator | Facts | Analysis | Conclusion |
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| | and "additional information.<br><br>In other words, the methodology does not clearly include requirements to identify objective corrective actions for all deficiencies or for the closure to ensure timely completion. | | |

## V.D.3 Analysis of 23rd 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 |
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| 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 had previously established three Key Performance Areas (KPAs) that address the eight domains listed in V.D.3.a-h. For the 23rd Period review, the *Developmental Disabilities Quality Management Plan State Fiscal Year 2024*, dated 8/13/23, indicated these remained in effect.<br><br>As detailed with regard to | DBHDS had previously established three Key Performance Areas (KPAs) that address the eight domains listed in V.D.3.a-h.<br>• 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.<br>• The Community Integration and Inclusion KPA workgroup encompasses the domains of: a) Community Inclusion, b) Choice and Self-Determination and c) Stability.<br>• The Provider Competency and Capacity KPA workgroup encompasses the domains of: a) Provider Capacity and b) Access to Services.<br><br>For the 23rd Period review, the *Developmental Disabilities Quality Management Plan State Fiscal Year 2024*, dated 8/13/23, indicated these remained in effect.<br>For this 23rd period Review, as described in detail with regard to CI 36.1 and CI 36.4 | 21st - Met*<br><br>**23rd - Met** |

| Compliance Indicator | Facts | Analysis | Conclusion |
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| 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 | 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 Improvement Committee (QIC).<br><br>As described 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.<br><br>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 complies with the requirements to monitor progress towards achievement of PMI targets and to recommend and prioritize quality improvement initiatives to address identified issues. | 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.<br><br>As described above for CI 36.1 and for CI 38.1 below with regard to data quality for the source systems, overall, DBHDS has at least minimally implemented the requirements of the *Curative Action for Data Validity and Reliability*. | |

| Compliance Indicator | Facts | Analysis | Conclusion |
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| | As described above for CI 36.1 and for CI 38.1 below with regard to data quality for the source systems, overall, DBHDS has at least minimally implemented the requirements of the *Curative Action for Data Validity and Reliability*. | | |
| 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. | Overall, DBHDS fulfilled the requirements of this Indicator.<br><br>For this 23rd Period Review, based on four quarters of QIC minutes (i.e., SFY23 Q2 and Q4 and SFY24 Q1 and Q2), the QIC workgroups reported to the QIC on identified PMIs, outcomes, and quality initiatives. The OCQM also led an annual review of PMIs 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 | For this 23rd Period Review, based on four quarters of QIC minutes (i.e., SFY23 Q2 and Q4 and SFY24 Q1 and Q2), the QIC workgroups reported to the QIC on identified PMIs, outcomes, and quality initiatives. The OCQM also led an annual review of PMIs 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 Processes*, revised 6/29/23. DBHDS tracked the findings of the most recent annual review, including the decisions to add, abandon or revise PMIs, in the *SFY23 PMI Tracker with Annual PMI Review Updated Spring 2023*.<br><br>As described above for CI 36.1 and for CI 38.1 below with regard to data quality for the source systems, overall, DBHDS has at least minimally implemented the requirements of the *Curative Action for Data Validity and Reliability*. | 21st - Met*<br><br>**23rd - Met** |

| Compliance Indicator | Facts | Analysis | Conclusion |
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| | consistent with a thorough process described in a document entitled *PMI Development and Annual Review Processes*, revised 6/29/23. DBHDS tracked the findings of the most recent annual review, including the decisions to add, abandon or revise PMIs, in the *SFY23 PMI Tracker with Annual PMI Review Updated Spring 2023*.<br><br>As described above for CI 36.1 and for CI 38.1 below with regard to data quality for the source systems, overall, DBHDS has at least minimally implemented the requirements of the *Curative Action for Data Validity and Reliability*. | | |
| 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) | 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). | 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).<br><br>Based on review of workgroup and QIC minutes, for the 23rd Period, each KPA workgroup engaged in activities that allowed them to meet the criteria required for sub-indicators b) through i).<br><br>With regard to data validity and reliability, as described above for CI 36.1 and for CI | 21st - Met *<br><br>**23rd - Met** |

| Compliance Indicator | Facts | Analysis | Conclusion |
|---|---|---|---|
| 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 | Each KPA workgroup engaged in activities to implement sub-indicators b) through i).<br><br>With regard to data validity and reliability, as described above for CI 36.1 and CI 38.1 with regard to data quality for the source systems, overall, DBHDS has at least minimally implemented the requirements of the *Curative Action for Data Validity and Reliability*. | 38.1 with regard to data quality for the source systems, overall, DBHDS has at least minimally implemented the requirements of the *Curative Action for Data Validity and Reliability*. | |
| 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 | DBHDS workgroups and committees collected surveillance data from a variety of data sources.<br><br>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. | For this 23rd Period review, as described below, DBHDS workgroups and committees continued to collect surveillance data from a variety of data sources.<br><br>Based on review of workgroup and committee minutes and of surveillance data reporting provided for review, 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.<br><br>As described above for CI 36.1 and for CI 38.1 below with regard to data quality for the source systems, overall, DBHDS has at least minimally implemented the requirements of the *Curative Action for Data Validity and Reliability*. | 21st - Met*<br><br>**23rd - Met** |

| Compliance Indicator | Facts | Analysis | Conclusion |
|---|---|---|---|
| serves as a source for establishing PMIs and/or quality improvement initiatives. | As described above for CI 36.1 and for CI 38.1 below with regard to data quality for the source systems, overall, DBHDS has at least minimally implemented the requirements of the *Curative Action for Data Validity and Reliability*. | | |
| 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. | Overall, DBHDS fulfilled the requirements of this Indicator.<br><br>As described with regard to CI 29.1 and CI 36.1 above, part of the *Curative Action for Data Validity and Reliability* re-defined responsibilities and methodologies for the assessment of data reliability and validity of the data sets for the PMIs described in V.D.2, indicators 1 and 5.<br><br>V.D.2 indicator 1 (i.e., CI 36.1) now requires an adequately completed Process Document (i.e., which replaced the PMI Methodology) and a Data | As described with regard to CI 29.1 and CI 36.1 above, part of the *Curative Action for Data Validity and Reliability* re-defined responsibilities and methodologies for the assessment of data reliability and validity of the data sets for the PMIs described in V.D.2, indicators 1 and 5. These now require an adequately completed Process Document (i.e., which replaced the PMI Methodology) and a Data Set Attestation. The OCQM (i.e., the DBHDS entity now assigned to complete the responsibilities previously assigned to the now defunct Office of Data Quality and Visualization) completes the former while the CDO issues the latter.<br><br>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. As described above for CI 36.1, for this 23rd Period review, DBHDS at least minimally met these requirements.<br><br>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 | 21st - Not Met<br><br>**23rd - Met** |

| Compliance Indicator | Facts | Analysis | Conclusion |
|---|---|---|---|
| | Set Attestation. The OCQM (i.e., the DBHDS entity now assigned to complete the responsibilities previously assigned to the now defunct Office of Data Quality and Visualization) completes the former while the CDO issues the latter.<br><br>For this 23rd Period review, as described above for CI 36.1 and CI 38.1, overall, DBHDS has at least minimally implemented the requirements of the *Curative Action for Data Validity and Reliability*.<br><br>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. As described above for CI 36.5, for this 23rd Period review, DBHDS met these requirements. | PMI describe a complete and thorough description of the specific steps used to supply the numerator and denominator for calculation. As described above for CI 36.5, for this 23rd Period review, DBHDS met these requirements. | |

| Compliance Indicator | Facts | Analysis | Conclusion |
|---|---|---|---|
| 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) | The HSWB KPA workgroup and RMRC developed and initiated performance measures for "safety and freedom from harm."<br><br>Each included a set target, or goal.<br><br>DBHDS assigned HSWB KPA workgroup or RMRC to monitor each performance measure.<br><br>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.<br><br>As described above for CI 36.1 and for CI 38.1 below with regard to data quality for the source systems, overall, DBHDS has at least minimally implemented the requirements of the *Curative Action for Data Validity and Reliability*. | As referenced in the corresponding chart for CI 36.4 above, 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<br><br>As described above for CI 36.1 and for CI 38.1 below with regard to data quality for the source systems, overall, DBHDS has at least minimally implemented the requirements of the *Curative Action for Data Validity and Reliability*. | 21st Met *<br><br>**23rd - Met** |

| Compliance Indicator | Facts | Analysis | Conclusion |
|---|---|---|---|
| 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."<br><br>Each included a set target, or goal.<br><br>DBHDS assigned HSWB KPA workgroup, MRC or CMSC to monitor each performance measure.<br><br>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.<br><br>As described above for CI 36.1 and for CI 38.1 below with regard to data quality for the source systems, overall, DBHDS has at least minimally implemented the requirements of the *Curative Action for Data* | As referenced in the corresponding chart for CI 36.4 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<br><br>As described above for CI 36.1 and for CI 38.1 below with regard to data quality for the source systems, overall, DBHDS has at least minimally implemented the requirements of the *Curative Action for Data Validity and Reliability*. | 21st - Met *<br><br>**23rd - Met** |

| Compliance Indicator | Facts | Analysis | Conclusion |
|---|---|---|---|
| | *Validity and Reliability*. | | |
| 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 | The HSWB KPA workgroup developed one performance measure for "avoiding crises."<br><br>Each included a set target, or goal.<br><br>DBHDS assigned the HSWB KPA workgroup to monitor the performance measure.<br><br>Based on a review of meeting minutes DBHDS submitted, the HSWB KPA workgroup monitored the performance measures.<br><br>As described above for CI 36.1 and for CI 38.1 below with regard to data quality for the source systems, overall, DBHDS has at least minimally implemented the requirements of the *Curative Action for Data Validity and Reliability*. | As referenced in the chart for CI 36.4 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.<br><br>As described above for CI 36.1 and for CI 38.1 below with regard to data quality for the source systems, overall, DBHDS has at least minimally implemented the requirements of the *Curative Action for Data Validity and Reliability*.<br>. | 21st - Met *<br><br>**23rd - Met** |

| Compliance Indicator | Facts | Analysis | Conclusion |
|---|---|---|---|
| 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."<br><br>Each included a set target, or goal. DBHDS assigned the CII KPA workgroup to monitor each performance measure.<br><br>Based on a review of meeting minutes DBHDS submitted, the CII KPA monitored each of the assigned performance measures.<br><br>As described above for CI 36.1 and CI 38.1 with regard to data quality for the source systems, overall, DBHDS has at least minimally implemented the requirements of the *Curative Action for Data Validity and Reliability*. | As referenced in the corresponding chart for CI 36.4 above, the CII KPA workgroup developed and initiated three 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<br><br>As described above for CI 36.1 and for CI 38.1 below with regard to data quality for the source systems, overall, DBHDS has at least minimally implemented the requirements of the *Curative Action for Data Validity and Reliability*.<br>. | 21st - Met *<br><br>**23rd - Met** |
| 37.17: The Community Inclusion/Integrated Settings KPA workgroup will finalize surveillance data to be collected for | As reported at the time of the previous review and as evidenced in the document entitled *SFY24 KPA Workgroups Schedule* | As reported at the time of the previous review and as evidenced in the document entitled *SFY24 KPA Workgroups Schedule with Surveillance Data Requirements,* updated 8/15/23, the CII KPA workgroup proposed surveillance data to be collected for "choice and self-determination." | 21st - Met<br><br>**23rd - Met** |

| Compliance Indicator | Facts | Analysis | Conclusion |
|---|---|---|---|
| "Choice and self-determination." | *with Surveillance Data Requirements,* updated 8/15/23, the CII KPA workgroup proposed surveillance data to be collected for "choice and self-determination." | | |
| 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."<br><br>Each included a set target, or goal.<br><br>DBHDS assigned the CII KPA workgroup or the CMSC to monitor each performance measure.<br><br>Based on a review of meeting minutes DBHDS submitted, the CII KPA and CMSC respectively monitored each of the assigned performance measures.<br><br>As described above for CI 36.1 and for CI 38.1 below with regard to data quality for the source | As referenced in the corresponding chart for CI 36.4 above, the CII KPA workgroup and the CMSC developed and initiated three 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.<br><br>As described above for CI 36.1 and for CI 38.1 below with regard to data quality for the source systems, overall, DBHDS has at least minimally implemented the requirements of the *Curative Action for Data Validity and Reliability*. | 21st - Met*<br><br>**23rd - Met** |

| Compliance Indicator | Facts | Analysis | Conclusion |
|---|---|---|---|
| | systems, overall, DBHDS has at least minimally implemented the requirements of the *Curative Action for Data Validity and Reliability*. | | |
| 37.20: The Community Inclusion/Integrated Settings KPA workgroup will develop, initiate, and monitor performance measures with a set target. Measures may be selected from, but not limited to, any of the following data sets: Employment; Community Engagement/Inclusion; QSRs; Housing; Regional Support Teams; Home and Community-Based Settings; NCI – (i.e., Individual Outcomes); WaMS | The CII KPA workgroup and CMSC developed and initiated performance measures for "community inclusion."<br><br>Each included a set target, or goal.<br><br>DBHDS assigned the CII KPA workgroup and CMSC to monitor each performance measure.<br><br>Based on a review of meeting minutes DBHDS submitted, the CII KPA workgroup and CMSC respectively monitored each of the assigned performance measures.<br><br>As described above for CI 36.1 and for CI 38.1 below with regard to data quality for the source systems, overall, DBHDS has at least minimally | As referenced in the corresponding chart for CI 36.4 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<br><br>As described above for CI 36.1 and for CI 38.1 below with regard to data quality for the source systems, overall, DBHDS has at least minimally implemented the requirements of the *Curative Action for Data Validity and Reliability*.<br>. | 21st – Met*<br><br>**23rd - Met** |

| Compliance Indicator | Facts | Analysis | Conclusion |
|---|---|---|---|
| | implemented the requirements of the *Curative Action for Data Validity and Reliability*. | | |
| 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 | The PCC KPA workgroup and CMSC developed and initiated performance measures for "choice and self-determination."<br><br>Each included a set target, or goal.<br><br>DBHDS assigned a specific KPA workgroup or other DBHDS to monitor each performance measure.<br><br>Based on a review of meeting minutes DBHDS submitted, the PCC KPA workgroup and CMSC respectively monitored each of the assigned performance measures.<br><br>As described above for CI 36.1 and for CI 38.1 below with regard to data quality for the source systems, overall, DBHDS has at least minimally | As referenced in the corresponding chart for CI 36.4 above, the PCC KPA workgroup and the CMSC developed and initiated four 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.<br><br>As described above for CI 36.1 and for CI 38.1 below with regard to data quality for the source systems, overall, DBHDS has at least minimally implemented the requirements of the *Curative Action for Data Validity and Reliability*. | 21st – Met*<br><br>**23rd - Met** |

| Compliance Indicator | Facts | Analysis | Conclusion |
|---|---|---|---|
| | implemented the requirements of the *Curative Action for Data Validity and Reliability*. | | |
| 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.<br><br>As described above for CI 36.1 and for CI 38.1 below with regard to data quality for the source systems, overall, DBHDS has at least minimally implemented the requirements of the *Curative Action for Data Validity and Reliability*. | As referenced in the corresponding chart for CI 36.4 above, the PCC KPA workgroup and the CMSC 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.<br><br>As described above for CI 36.1 and for CI 38.1 below with regard to data quality for the source systems, overall, DBHDS has at least minimally implemented the requirements of the *Curative Action for Data Validity and Reliability*. | 21st – Met*<br><br>**23rd - Met** |

## V.D.4 Analysis of 23rd Review Period Findings

**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.**

| 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 | For this 23rd Period review, DBHDS continued to collect data from each of these sources or, in some instances, their replacements (i.e., CONNECT).<br><br>For this 23rd Period review, as described further with regard to 36.1 above, DBHDS provided the *Data Quality Monitoring Plan Source System Report*, dated 9/28/23. DBHDS also completed a source system review or update (i.e., review of completion criteria for previous *Actionable Recommendations*) for 16 data sources. | 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 23rd Period review, DBHDS continued to collect data from each of these sources or, in some instances, their replacements (i.e., CONNECT).<br><br>For this 23rd Period review, as described further with regard to 36.1 above, DBHDS provided the *Data Quality Monitoring Plan Source System Report*, dated 9/28/23, DBHDS also completed a source system review or update (i.e., review of completion criteria for previous *Actionable Recommendations*) for the following data sources:<br>1. Avatar<br>2. Children in Nursing Facilities Spreadsheet<br>3. CHRIS- Serious Incident Report (SIR)<br>4. CHRIS-Human Rights (HR)<br>5. Community Consumer Submission 3 (CCS3)<br>6. CONNECT<br>7. Consolidated Employment Spreadsheet<br>8. Protection and Advocacy Incident Reporting System (PAIRS)<br>9. Quality Service Review (QSR)<br>10. Regional Educational Assessment Crisis Habilitation (REACH)<br>11. Support Coordination Quality Review (SCQR)<br>12. Waiver Management System (WaMS) Individual Support Plan (ISP) Proper<br>13. WaMS Customized Rate Module | 21st - Not Met<br><br>**23rd - Met** |

| Compliance Indicator | Facts | Analysis | Conclusion |
|---|---|---|---|
| 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 | | 14. WaMS Individual and Family Support Program (IFSP) Module<br>15. WaMS Regional Support Team (RST) Module<br>16. WaMS Waitlist Module | |

## V.D.5 Analysis of 23rd 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 |
|---|---|---|---|
| 39.4: 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). | Overall, DBHDS fulfilled the requirements of this Indicator.<br><br>For this 23rd Period review, a review of RQC minutes and materials for the last four quarters (i.e., SFY 23 Q3 and Q4, and SFY24 Q1 and Q2), the findings were consistent with those from the previous period, which found that the DBHDS staff members made presentations of relevant data reports for review by the RQC members. The minutes consistently showed the RQCs were provided with comparisons with other internal or external data, as appropriate, as well as multiple years of data, as available.<br><br>For this 23rd Period, as described above for CI 36.1 and for CI 38.1 with regard to data quality for the | At the time of the 21st 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. In addition, 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. 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.<br><br>For this 23rd Period review, based on a review of RQC minutes and materials for the last four quarters (i.e., SFY 23 Q3 and Q4, and SFY24 Q1 and Q2), the findings were consistent with those from the previous period.<br><br>At the time of the 21st Period, DBHDS had not demonstrated that the data presented were valid and reliable. However, for this 23rd Period, as described above for CI 36.1 and for CI 38.1 with regard to data quality for the source systems, overall, DBHDS has at least minimally implemented the requirements of the *Curative Action for Data Validity and Reliability*. | 21st - Met*<br><br>**23rd - Met** |

| Compliance Indicator | Facts | Analysis | Conclusion |
|---|---|---|---|
| | source systems, overall, DBHDS has at least minimally implemented the requirements of the *Curative Action for Data Validity and Reliability*. | | |
| 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. | Overall, DBHDS fulfilled the requirements of this Indicator.<br><br>For this 23rd Period, based on the minutes for each RQC for the last two quarters (i.e., SFY24 Q1 and Q2), the study found sustained performance with the 21st Period findings 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, and that the minutes reflected discussion of possible trends and requests for additional data that might inform quality improvement initiatives. In addition, the studies found the data presentations often provided data in a manner that facilitated the ability of the RQC members to visualize | At the time of the 21st 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, and that the minutes reflected discussion of possible trends and requests for additional data that might inform quality improvement initiatives. In addition, the study found the data presentations often provided data in a manner that facilitated the ability of the RQC members to visualize possible trends. However, at that time, DBHDS had not demonstrated that the data they provided to the RQCs were valid and reliable and therefore could not be used for compliance reporting.<br><br>For this 23rd Period, based on the minutes for each RQC for the last two quarters (i.e., the study found sustained performance. With regard to data validity and reliability, as described above for CI 36.1 and CI 38.1 with regard to data quality for the source systems, overall, DBHDS has at least minimally implemented the requirements of the *Curative Action for Data Validity and Reliability*. | 21st - Met*<br><br>**23rd - Met** |

| Compliance Indicator | Facts | Analysis | Conclusion |
|---|---|---|---|
| | possible trends.<br><br>For the 23rd Period, with regard to data validity and reliability, as described above for CI 36.1 and CI 38.1 with regard to data quality for the source systems, overall, DBHDS has at least minimally implemented the requirements of the *Curative Action for Data Validity and Reliability*. | | |

## V.D.5.b Analysis of 23rd Review Period Findings

**Section V.D.5.b: Each council shall meet on a quarterly basis to share regional data, trends, and monitoring efforts and plan and recommend regional quality improvement initiatives. The work of the Regional Quality Councils shall be directed by a DBHDS quality improvement committee.**

| Compliance Indicator | Facts | Analysis | Conclusion |
|---|---|---|---|
| 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. | Overall, DBHDS fulfilled the requirements of this Indicator.<br><br>For this 23rd Period review, based on review of the QIC minutes for three quarters (i.e., Q2 SFY23, Q4 SFY23, and Q1 SFY 24), all five RQCs regularly reviewed and evaluated data, trends, and monitoring efforts.<br><br>Based on the QIC minutes for SFY23 Q4, during this review period, all five RQCs recommended at least one quality improvement initiative to the QIC annually.<br><br>With regard to data validity and reliability, as described above for CI 36.1 and CI 38.1 with regard to data quality for the source systems, overall, DBHDS has at least | At the time of the 21st Period review, the study found that minutes of the RQC meetings reflected review of data, trends and monitoring efforts, including at least one recommendation made to the QIC and follow-up from previous recommendations. The RQCs also recommended at least one quality improvement initiative to the QIC annually. The findings for the 23rd period were consistent with the previous review.<br><br>For this 23rd Period review, based on review of the QIC minutes for three quarters (i.e., Q2 SFY23, Q4 SFY23, and Q1 SFY 24), all five RQCs regularly reviewed and evaluated data, trends, and monitoring efforts.<br><br>Based on the QIC minutes for SFY23 Q4, during this review period, all five RQCs recommended at least one quality improvement initiative to the QIC annually. These included the following:<br>• RQC 1: Teen Employment Discussion<br>• RQC 2: Region 2 Employment Outcomes.<br>• RQC 3: Region 3 Dental Exams<br>• RQC 4: Region 4 Urinary Tract Infections (UTIs)<br>• RQC 5: Unpaid Relationships Discussion<br><br>With regard to data validity and reliability, as described above for CI 36.1 and CI 38.1 with regard to data quality for the source systems, overall, DBHDS has at least minimally implemented the requirements of the *Curative Action for Data Validity and Reliability*. As described with regard to CI 29.10, DBHDS also provided the requisite Process Documents for all current QIIs. | 21st - Met*<br><br>**23rd - Met** |

| | | | |
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| | minimally implemented the requirements of the *Curative Action for Data Validity and Reliability*. As described with regard to CI 29.10, DBHDS also provided the requisite Process Documents for all current QIIs. | | |
| 40.5: For each quality improvement initiative recommended by the RQC, at least one measurable outcome will be proposed by the RQC. | Overall, DBHDS fulfilled the requirements of this Indicator.<br><br>For the 23rd Period, as reported with regard to CI 29.10 above, QIIs were stated in measurable terms. In addition, the RQC QIIs included not only outputs, but at least one measurable outcome.<br><br>As described above for CI 36.1 and for CI 38.1 below with regard to data quality for the source systems, overall, DBHDS has at least minimally implemented the requirements of the *Curative Action for Data Validity and Reliability* | At the time of the 21st Period review, the study found that RQCs were using QII Toolkits to develop their proposed QIIs. These appeared to address the key components of measurability. The 23rd Period review findings were consistent with the previous report. As reported with regard to CI 29.10 above, QIIs were stated in measurable terms. In addition, the RQC QIIs included not only outputs, but at least one measurable outcome.<br><br>As described above for CI 36.1 and for CI 38.1 below with regard to data quality for the source systems, overall, DBHDS has at least minimally implemented the requirements of the *Curative Action for Data Validity and Reliability*. | 21st - Met*<br><br>**23rd - Met** |
| 40.7: The DBHDS QIC reviews the recommendations reported by the RQCs and directs the implementation | Overall, DBHDS fulfilled the requirements of this Indicator.<br><br>For the 23rd Period, based on | 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 QIC minutes for three quarters (i.e., Q2 SFY23, Q4 SFY23 and Q1 SFY 24), all five RQCs reported on the status of their existing, abandoned and/or proposed QIIs. These minutes | 21st - Met<br><br>**23rd - Met** |

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| of any quality improvement initiatives upon approval by the QIC and the Commissioner. Relevant Department staff may be assigned to statewide quality improvement initiatives to facilitate implementation. The QIC directs the RQC to monitor the regional status of any statewide quality improvement initiatives implemented and report annually to the DBHDS QIC on the current status. The DBHDS QIC reports back to each RQC at least once per year on any decisions and related implementation of RQC recommendations. If the QIC declines to support a quality improvement initiative recommended by a RQC, the QIC shall document why. | 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 QIC minutes for three quarters (i.e., Q2 SFY23, Q4 SFY23 and Q1 SFY 24), all five RQCs reported on the status of their existing, abandoned and/or proposed QIIs. These minutes also showed that RQCs monitored the regional status of statewide quality improvement initiatives and reported at least annually to the DBHDS QIC on the current status.<br><br>When the QIC declined to support a recommended QII, the QIC provided the RQC a written response to document the reason for the determination. This was in addition to the discussion documented during the QIC meetings. DBHDS provided evidence for each RQC in the form of a document entitled *The Quality Improvement Committee Report* for SFY22 Q4 and SFY23 Q1-Q4. These documents, prepared by OCQM, also documented the | also showed that RQCs monitored the regional status of statewide quality improvement initiatives and reported at least annually to the DBHDS QIC on the current status.<br><br>When the QIC declined to support a recommended QII, the QIC provided the RQC a written response to document the reason for the determination. This was in addition to the discussion documented during the QIC meetings. DBHDS provided evidentiary documentation for each RQC entitled *The Quality Improvement Committee Report* for SFY22 Q4 and SFY23 Q1-Q4. These documents, prepared by OCQM, also documented the QIC's responses to decisions and related implementation of RQC recommendations, as well as data requests. *The Quality Improvement Committee Reports* were thorough and comprehensive. | |

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| | QIC's responses to decisions and related implementation of RQC recommendations, as well as data requests. | | |

## V.E.1 Analysis of 23rd 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 Licensing**

| Compliance Indicator | Facts | Analysis | Conclusion |
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| 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. | Overall, DBHDS fulfilled the requirements of this Indicator.<br><br>For the 23rd Period review, DBHDS reported data that met the requirement for this CI. During Calendar Year (CY) 2022, the percentage of licensed providers of DD services assessed for compliance with *12 VAC 35-105- 620* during their annual inspections had reached 93%. CY 2022 included the first and second quarters of SFY 2023 (i.e., 7/1/22-9/30/22 and 10/1/22-12/31/22). For the third and fourth quarters of SFY 2023 (i.e., 1/1/23 through | For the 21st Period review, based on self-reported data, this CI was not met. However, for this 23rd Period review, DBHDS reported that during Calendar Year (CY) 2022, the percentage of licensed providers of DD services assessed for compliance with *12 VAC 35-105- 620* during their annual inspections had reached 93%. CY 2022 included the first and second quarters of SFY 2023 (i.e., 7/1/22-9/30/22 and 10/1/22-12/31/22). For the third and fourth quarters of SFY 2023 (i.e., 1/1/23 through 3/31/23 and 4/1/23-through 6/30/23), DBHDS reported 96% and 95% respectively.<br><br>For this 23rd Period review, with regard to data reliability and validity, DBHDS provided a revised Process Document and an updated Data Set Attestation. The Process Document, entitled *Quality Improvement Program Compliance, Version 004*, was last revised on 8/23/23 and a relevant Data Set Attestation, dated 8/30/23. These documents met the requirements of the *Curative Action for Data Validity and Reliability*. | 21st - Not Met<br><br>**23rd - Met** |

| Compliance Indicator | Facts | Analysis | Conclusion |
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| | 3/31/23 and 4/1/23-through 6/30/23), DBHDS reported 96% and 95% respectively.<br><br>With regard to data reliability and validity, DBHDS provided a revised Process Document and an updated Data Set Attestation. The Process Document, entitled *Quality Improvement Program Compliance, Version 004*, was last revised on 8/23/23 and a relevant Data Set Attestation, dated 8/30/23. These documents met the requirements of the *Curative Action for Data Validity and Reliability*. | | |
| 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. | For the 23rd Period, based on self-reported data, this CI is not met because the percentage of compliance for each of the past four reported quarters did not reach 86%.<br><br>For this 23rd Period review, as described with regard to CI 42.3, DBHDS provided an | At the time of the 21st Period review, through 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 and every one of the 11 sub-regulations (i.e., *620 A, 620 B, 620 C1-C5, 620 D1-D3* and *620 E)* and including an evaluation of whether the provider was implementing its QI plan. Based on self-reported data at that time, during 2021, only 52% of providers were compliant with *12 VAC 35-105-620* as a whole. In the first two quarters of 2022, the percentage of compliant providers did not exceed 54%.<br><br>For this 23rd Period review, DBHDS provided the following data for review:<br>• For the 2022 calendar year (i.e., 1/1/22 through 12/31/22), DBHDS provided a report that documented the percentage of | 21st - Not Met<br><br>**23rd - Not Met** |

| Compliance Indicator | Facts | Analysis | Conclusion |
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| | appropriately completed Process Document, entitled *Quality Improvement Program Compliance, Version 004*, revised on 8/23/23 and Data Set Attestation, dated 8/30/23. With regard to data reliability and validity, DBHDS sufficiently reconciled concerns with the methodologies found during 21st Period. However, to ensure the data continue to be sufficiently representative, DBHDS might consider modifying the Process Document to require that the denominator must always be of sufficient size to reach a 95% confidence level for all providers who had an annual unannounced inspection during the year. | providers that were compliant with 100% of the quality improvement regulations at 56%. The calendar year included the first two quarters of SFY 2023 (i.e., 7/1/22-9/30/22 and 10/1/22-12/31/22).<br>• Specifically for the second quarter of the SFY 2023 (i.e., 10/1/22 through 12/31/22, DBHDS provided a report that documented the percentage of providers that were compliant with 100% of the quality improvement regulations at 51%.<br>• For the third quarter of SFY 2023 (i.e., 1/1/23 through 3/31/23), DBHDS provided a report that documented the percentage of providers that were compliant with 100% of the quality improvement regulations at 60%.<br>• For the fourth quarter of SFY 2023 (i.e., 4/1/23-through 6/30/23), DBHDS provided a report that documented the percentage of providers that were compliant with 100% of the quality improvement regulations at 58%.<br><br>Further, for FY23, the Commonwealth reported it achieved the 86% benchmark for only six of the 11sub-regulations. The cumulative data for the four quarters of FY23 showed that the Commonwealth met the benchmark for 620A, 620B, 620C1, 620C3, 620D2 and 620E, but did not meet the benchmark for 620C2, 620C4, 620C5, 620D1 and 620D3, although it was close to achieving compliance with 620D1 at 85%.<br><br>For sub-regulations 620C2, 620C4, 620C5, 620D3 and 620E, to achieve compliance, the Commonwealth needs to achieve more substantial progress and improvement. This was particularly evident for 620C4 (i.e., for the provider QI plan to monitor implementation and effectiveness of approved CAPs) and 620D3 ( i.e., for provider policy and procedure to require submission of revised CAPs when previous CAPs were not effective) for which providers had not achieved the benchmark during any quarter for either FY22 or FY23. Similarly, for each of 620C2 (i.e., for the provider QI plan to define measurable goals and objectives) and for 620C5 (i.e., for the provider QI Plan to include ongoing monitoring and evaluation of progress toward meeting goals), providers had achieved the benchmark in only one quarter out of eight in FY22 and FY23. | |

| Compliance Indicator | Facts | Analysis | Conclusion |
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| | | To achieve compliance for each of these, the Commonwealth should require underperforming providers to complete and implement a CAP that should include the receipt of technical assistance, additional training, and specific actions related to their respective areas of underperformance. In addition, if the Provider does not meet the required metrics in its next licensing inspection, DBHDS should issue sanctions to enforce adherence to the Commonwealth's regulations.<br><br>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. At the time of the 21st Period review, this continued to need resolution.<br><br>For this 23rd Period review, as described with regard to CI 42.3, DBHDS provided the Process Document entitled *Quality Improvement Program Compliance, Version 004*, revised on 8/23/23. With regard to data reliability and validity, DBHDS sufficiently reconciled concerns with the methodologies found during 21st Period. In summary, at that time, the calculation for the denominator excluded providers who had an unannounced licensing inspection within the year, but for whom the inspection did not fully review compliance with 12 VAC 35-105- 620. In other words, their compliance status was unknown. This had the potential to skew the resulting data reports since the denominator for the measure was not 100% of the providers that had annual licensing inspections, but rather a lower percentage. Given the very high compliance with CI 42.3 (i.e., ranging from 93%-96% over the last six quarters), the data discrepancy for this 23rd Period was not substantial.<br><br>However, if compliance with CI 42.3 were to drop significantly, the impact on the data validity for this CI would be magnified. It is unlikely that such a significant drop will occur in the future, given the regulatory requirements that require DBHDS to assess provider compliance with *12 VAC 35-105- 620* during their annual inspections. However, to ensure the data continue to be sufficiently representative, DBHDS might consider modifying the Process Document to require that the denominator must always be of sufficient size to | |

| Compliance Indicator | Facts | Analysis | Conclusion |
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| | | reach a 95% confidence level for all providers who had an annual unannounced inspection during the year. | |
| 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 the current *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 the requirements for CI 42.05. | At the time of the 21st Period review, DBHDS provided an updated DI 316, effective 04/7/21. The document addressed all of the requirements for CI 42.5. For this 23rd Period review, the DI remained in effect. | 21st - Met<br><br>**23rd - Met** |

## V.E.2 Analysis of 23rd 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 |
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| 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 | Overall, DBHDS fulfilled the requirements of this Indicator.<br><br>On 11/9/21, the Parties agreed upon a Curative Action, and filed it with the Court. 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 would use | The 22nd Period study reported that the Parties had agreed upon a Curative Action, filed with the Court on 11/9/21. In addition to the ongoing provider reporting of 12 surveillance measures representing risks that are prevalent in individuals with developmental disabilities (e.g., aspiration, bowel obstruction, sepsis, etc.), this Curative Action required DBHDS to develop and track provider reporting measures that assess both positive and negative aspects of health and safety and of community integration through the QSR process. These latter measures utilize data from three PQR questions to evaluate the following provider reporting measure: 86% of providers demonstrate a commitment to community inclusion by demonstrating actions that lead to participation in community integration activities. This measure was intended to define the demonstration of commitment to community inclusion based on the extent to which providers demonstrate the following:<br><br>a. N: The number of providers who promote meaningful work/ D: Number of providers reviewed<br>b. N: The number of providers who promote individual participation in non-large group activities/D: Number of providers reviewed<br>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<br><br>For this 23rd Period, the specific requirements, and the current status of each, of | 21st Not Met<br><br>**23rd - Met** |

| Compliance Indicator | Facts | Analysis | Conclusion |
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| 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. | data from three PQR questions to evaluate the following provider reporting measure for promotion of community integration.<br><br>The Curative Action also required DBHDS to continue to 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 these measures, for which data are collected through CHRIS-SIR, DBHDS informed providers of these requirements through regulations at *12VAC35-105-160*.<br><br>In addition, on 8/27/23, DBHDS sent a memorandum to providers of developmental disability services describing expectations regarding provider risk management programs and provider reporting | the Curative Action are described below for this CI and for CI 43.2 below:<br><br>• *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*: For Round 4 and Round 5, the QSR vendor presented data to providers and to DBHDS.<br><br>• *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:* Based on QIC and subcommittee minutes and materials, DBHDS tracked and addressed overall statewide results. Data on the 12 surveillance measures are traditionally reported in the *Developmental Disabilities Annual Report and Evaluation,* while QSR reports for Round 4 and Round include performance for the community integration provider reporting measures. The latter are posted on the DBHDS website and on the Library Site.<br><br>• *To ensure reliability and validity, DBHDS will ensure that appropriate tools that specify the parameters for collecting this data are made available to providers. 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.* For Round 4 and Round 5 of QSRs, DBHDS has used the process to collect data with regard to the community integration provider reporting measure described above.<br><br>In addition, on 8/27/23, DBHDS sent a memorandum to providers of developmental disability services describing expectations regarding provider risk management programs and provider reporting measures. The memorandum stated that DBHDS uses provider reporting data from critical incidents, the Risk Awareness tool and the ISP to report on positive and negative aspects of health and safety, and data from Quality | |

| Compliance Indicator | Facts | Analysis | Conclusion |
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| | measures.<br><br>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). DBHDS provided this information to providers in the aforementioned 8/27/23 memorandum.<br><br>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 utilized a sufficient methodology to reach its findings. For the 23rd Period, as reported with regard to CI 36.1, while concerns remained with | Service Reviews, Semi-Annual Employment Report, NCI, and ISPs for provider reporting measures of positive and negative aspect of community integration. Further, the memorandum stated that each provider should have in their Quality Improvement Plan a specific measure that addresses the promotion/participation in community integration as defined by meaningful work activities, non-large group activities (community engagement) and individual participation in community outings. The document gave examples and also defined "meaningful work" as individual supported employment or group supported employment in a setting where individuals have the opportunity to interact with non-disabled individuals, and "meaningful community inclusion" as activities that are delivered in a group of 3 individuals or fewer, are based on the person's preferences and choice and completed with people with the person prefers to engage with.<br><br>• *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 for the 23rd Period, the RMRC continues to collect for these 12 surveillance measures related to negative aspects of health and safety. As previously reported, For the measures for which data are collected through CHRIS-SIR, DBHDS informed providers of these requirements through regulations at *12VAC35-105-160*.<br><br>In addition, the provider reporting measure memorandum DBHDS sent | |

| Compliance Indicator | Facts | Analysis | Conclusion |
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| | regard to the adequacy of IRR, and its potential impact on data validity and reliability, DBHDs at least minimally met the requirements to evaluate the QSR as a data source system and to provide a Process Document (i.e., entitled *QSR Quality Improvement Findings*, dated 8/1/23), and a Data Set Attestation, dated 9/9/23. | to providers on 8/27/23 included expectations for these measures. It explained that, as part of their quarterly reviews of serious incidents, providers are expected to conduct an analysis of trends, potential systemic issues or causes, indicated remediation, and documentation of steps taken to mitigate the potential for future incidents. In addition, it clarified that DBHDS will monitor providers and provider risk management systems to ensure that providers are reviewing and trending data related to risk and taking steps to mitigate future harm pursuant to *12VAC35-105-160* and *12VAC35-105-520(C)*, and that DBHDS would update the licensing review protocols to be used by OL to include the expectation that providers review and evaluate trends and identify risks and take action as necessary to mitigate the risk of harm to individuals receiving services. The licensing review protocols will include the expectation that providers identify potential remediation actions and take action to mitigate the potential for future incidents as needed. Finally, to facilitate achieving compliance with this indicator, the memo detailed the guidelines and tools to assist providers to do so, and provided links.<br><br>• *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, integrated work opportunities, integrated living options, educational opportunities, relationships with non-paid individuals).* As noted above, the provider reporting measures include both physical health and community inclusion.<br><br>• *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* | |

| Compliance Indicator | Facts | Analysis | Conclusion |
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| | | *DBHDS utilized a sufficient methodology to reach its findings:* At the time of the 21st Period review, this has not yet occurred. For the 23rd Period, as reported with regard to CI 36.1, while concerns remained with regard to the adequacy of IRR, and its potential impact on data validity and reliability, DBHDs at least minimally met the requirements to evaluate the QSR as a data source system and to provide a Process Document (i.e., entitled *QSR Quality Improvement Findings*, dated 8/1/23) and a Data Set Attestation, dated 9/9/23. | |
| 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 annually and update accordingly. | Previous reports have documented that the Office of Data Quality and Visualization assisted with analysis of the 12 surveillance provider reporting measure.<br><br>In addition, for the 23rd Period review, OCQM staff reported the provider measures above were included in the annual PMI review as described with regard to CI 37.2 above. | Previous reports have documented that the Office of Data Quality and Visualization assisted with analysis of the 12 surveillance provider reporting measure. In addition, for the 23rd Period review, OCQM staff reported the provider measures above were included in the annual PMI review as described with regard to CI 37.2 above. | 21st - Not Met<br><br>**23rd - Met** |
| 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 | Overall, DBHDS at least minimally met the requirements of this Indicator.<br><br>For this review, per the applicable Curative | At the time of the 22nd Period review, per the applicable Curative Action described above, DBHDS had defined provider reporting measures in all required domains. For this 23rd Period, these continued in effect. In addition, the QIC monitored and reviewed the provider measures at least semi-annually with input from Regional Quality Councils.<br><br>At the time of the 22nd Period, DBHDS had not been able to review or analyze | 21st - Not Met<br><br>**23rd - Met** |

| Compliance Indicator | Facts | Analysis | Conclusion |
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| 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. | Action described above, DBHDS had defined provider reporting measures in all required domains. In addition, the QIC monitored and reviewed the provider measures at least semi-annually with input from Regional Quality Councils.<br><br>At the time of the 22nd Period, DBHDS had not been able to review or analyze serious incident data for approximately one year, which resulted in a finding of Not Met. However, for this 23rd Period, as described with regard to CI 29.13, DBHDS had met the requirements to review valid and reliable data for the 12 surveillance measures four times during the past year.<br><br>Overall, for the QSR-derived data, as described with regard to CI 36.1 above, DBHDS has at least minimally implemented the | serious incident data for approximately one year, which resulted in a finding of Not Met. However, for this 23rd Period, as described with regard to CI 29.13, DBHDS had met the requirements to review valid and reliable data for the 12 surveillance measures four times during the past year.<br><br>Overall, for the QSR-derived data, as described with regard to CI 36.1 above, DBHDS has at least minimally implemented the requirements of the *Curative Action for Data Validity and Reliability*. | |

| Compliance Indicator | Facts | Analysis | Conclusion |
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| | requirements of the *Curative Action for Data Validity and Reliability*. | | |

## V.E.3 Analysis of 23rd 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 |
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| 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 | For the 23rd Period, DBHDS continued to use the PQR tool, which included six elements relevant to the determination of the adequacy of providers' quality improvement programs, while a seventh element called for a narrative to list any "No" findings and describe any opportunities for improvement related to the provider Quality Improvement Plan<br><br>DBHDS and the vendor had also refined the guidance and evaluation | At the time of the 21st Period, this study found that the questions, evaluation criteria and additional guidelines in the QSR PQR tool 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. It was therefore not clear that the data could be considered valid or reliable.<br><br>For the 23rd Period, DBHDS continued to use the PQR tool, which included six elements relevant to the determination of the adequacy of providers' quality improvement programs, while a seventh element called for a narrative to list any "No" findings and describe any opportunities for improvement related to the provider Quality Improvement Plan. DBHDS and the vendor had also refined the guidance and evaluation criteria for use by reviewers when making determinations. Overall, this study found that DBHDS had significantly enhanced the guidance, as described below:<br><br>**1. Does the agency have a QI policy and procedure?**<br>A "Yes" rating is indicated when the provider has a QI program policy/procedure that defines how to:<br>1. Explains when to use various quality improvement tools and | 21st - Not Met<br><br>**23rd - Met** |

| Compliance Indicator | Facts | Analysis | Conclusion |
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| 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. | criteria for use by reviewers when making determinations. Overall, this study found that DBHDS had significantly enhanced the guidance.<br><br>With regard to data validity and reliability, DBHDS provided a Process Document entitled *DOJ Process QSR Quality Improvement Program Findings VER001*, dated 8/1/23, and a Data Set Attestation, dated 9/9/23.<br><br>While this met the minimum requirements of the Curative Action for Data Validity and Reliability, it remained concerning that neither of the documents acknowledged or addressed the IRR deficiencies that multiple Reports to the Court have previously identified.<br><br>None of the documentation provided indicated the steps DBHDS had taken since the previous review to | processes.<br>2. Establish measurable goals and objectives;<br>3. Update the provider's quality improvement plan; and<br>4. 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 to 12VAC35-105-170.<br>5. Providers track community inclusion for individuals receiving services For criteria 5: Reviewers should look to see that the QI program includes: 1)how the provider determines if its personnel promote meaningful work, 2) individuals' participation in non-large group activities and 3) how personnel encourage participation in community outings with people other than those with whom they live. All three elements must be included in the QI CSB or licensed DD service provider policy and procedure.<br><br>A "No" rating is indicated when provider does not have a QI policy and procedure, OR the provider's QI program policy and procedure is missing any of the above criteria This element is confirming the existence of a program policy and/or procedure that is distinct from providers' QI Plan. Reviewers must confirm evidence provider has over-arching quality improvement program that includes criteria 1-5 listed in scoring criteria.<br><br>**2. Does the agency have a QI plan?**<br>A "Yes" rating is indicated when the provider has a QI plan.<br>A "No" rating indicates that a QI Plan was not provided.<br><br>**3. Is the plan thorough?**<br>A "Yes" rating is indicated when the provider has a QI plan that | |

| Compliance Indicator | Facts | Analysis | Conclusion |
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| | improve the IRR process, especially to the point that it could be considered a rationale for attesting to data validity and reliability rather than an identified deficiency. Of note, as described with regard to CI 36.1 above, this study found similar concerns related to the source system assessment OCQM completed for QSR.<br><br>This study's sample of documents from a set of provider findings was not large enough to generalize the results, but there were some discrepancies between the QSR reviewers' findings and the results of the sample review. For example, for two providers for whom the QSR reviewer found no quality improvement deficiencies and DBHDS submitted the provider documents necessary to complete the review, the sample review found one provider did not meet the criteria for four of the six elements, while the other | meets the following criteria:<br>• 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;<br>• Define measurable goals and objectives;<br>• Include and report on statewide performance measures, as required by DBHDS; (Statewide performance measures are national core indicators (NCI) and specific to health and safety/high-risk health factors.<br>• Monitor implementation and effectiveness of approved corrective action plans pursuant to 12VAC35-105-170;<br>• Include ongoing monitoring and evaluation of progress toward meeting established goals and objects.<br>• Details how the provider plans to and is addressing any findings born out of the execution of the portion of the QI Program Policy and Procedure related to provider tracking of community inclusion for individuals receiving services<br>For the last bullet, expectation is that QI plan includes evidence that: 1) the process outlined in the QI Program Policy and Procedure was implemented; 2) the outcome of this process (if there were findings); and 3) if there were findings, the reviewer will need to review the plan to determine if it includes remediation steps to be taken and verify that these steps have been taken.<br><br>A "No" rating is indicated when any of the above criteria are not included in providers QI plan. This element is looking for the evaluation criteria to be included in the Quality Improvement plan and is an "all or nothing" element. Reviewers should note which specific aspects are not found in the plan within element "Describe any findings of No/opportunities for improvement related to the Risk Management Plan." This element will be scored "no" if element 14 – "Does the agency have a QI plan?" is selected as "no" or provider documentation only confirms QI policy and procedure, no evidence of a QI plan that meets the previously identified | |

| Compliance Indicator | Facts | Analysis | Conclusion |
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| | did not meet any of the six elements. For another eight providers, while the QSR reviewers found some deficiencies, they routinely did not identify all of the applicable concerns found in the sample review. | criteria.<br><br>**4. Is the plan complete?**<br>A "Yes" rating is indicated when the provider has a QI plan that includes the following elements:<br>• Design and scope<br>• Governance and leadership<br>• Feedback/data systems and monitoring<br>• Performance improvement projects<br>• Systemic analysis<br>• Systemic actions.<br>• Input from individuals receiving services and their authorized representatives, if applicable, about services used and satisfaction level of participation in the direction of service planning.<br><br>Reviewer should score "No" if any of the above criteria are note present in the plan. (Note that the guidance for this element does not state that it will be scored "no" if element 14 – "Does the agency have a QI plan?" is selected as "no" or provider documentation only confirms QI policy and procedure, no evidence of a QI plan that meets the previously identified criteria. However, it should.)<br><br>**5. The quality improvement plan is reviewed annually.**<br>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.<br>A "No" rating is indicated when review of documentation did not validate that the quality improvement plan is reviewed annually.<br>A "N/A" rating is indicated if the plan has been in place less than 1 year.<br><br>Reviewer Notes: | |

| Compliance Indicator | Facts | Analysis | Conclusion |
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| | | 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.<br>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.<br><br>**6. Providers have active quality management and improvement programs**<br>A "Yes" rating is indicated when review of documentation validated that the provider maintains an active quality management and improvement and risk management program either as separate plans or combined into one program that addresses both Quality and Risk<br>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.<br><br>Reviewer Notes:<br>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.<br>Reviewers may utilize the following resources document as a guide to assess the provider's quality management and risk management program.<br>DBHDS Guidance for Risk Management.pdf<br>DBHDS Guidance for a Quality Improvement Program Nov 2020.pdf | |

| Compliance Indicator | Facts | Analysis | Conclusion |
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| | | **7. Describe any findings of No/opportunities for improvement related to the Quality Improvement Plan.**<br>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.<br><br>Despite the improved guidance and QSR reviewer training,<br><br>For this 23rd Period, the QSR Vendor reported the following data for Round 5:<br><br>Does the agency have a QI program policy and procedure? 59%<br>Does the agency have a QI plan? 92%<br>Is the QI plan thorough? 53%<br>Is the QI plan complete? 72%<br>The quality improvement plan is reviewed annually. 76%<br>Providers have active risk management and quality improvement programs. 74%<br><br>With regard to data validity and reliability, DBHDS provided a Process Document entitled *DOJ Process QSR Quality Improvement Program Findings VER001,* dated 8/1/23, and a Data Set Attestation, dated 9/9/23. While this met the minimum requirements of the *Curative Action for Data Validity and Reliability*, it remained concerning that neither of the documents acknowledged or addressed the IRR deficiencies that multiple Reports to the Court have previously identified. The Process Document stated that "Concerns with QSR data were limited to those question where evaluation criteria were not clearly defined. The criteria for this question was clearly defined, no mitigation strategy warranted." The Data Set Attestation stated that "The reviewer notes for this element are detailed with regards to thoroughness and completeness. This along with the inter-rater reliability process the vendor has in place is sufficient to assert this data is reliable and valid." None of the documentation provided indicated the steps DBHDS had taken since the previous review to improve the IRR process, especially to the point that it could be considered a rationale for attesting to data | |

| Compliance Indicator | Facts | Analysis | Conclusion |
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| | | validity and reliability rather than an identified deficiency. Of note, as described with regard to CI 36.1 above, this study found similar concerns related to the source system assessment OCQM completed for QSR.<br><br>This study requested a sample of documents from a set of provider findings. While it was not large enough to generalize the results, there were some discrepancies between the QSR reviewers' findings and the results of the sample review. For example, for two providers for whom the QSR reviewer found no quality improvement deficiencies and DBHDS submitted the provider documents necessary to complete the review, the sample review found one provider did not meet the criteria for four of the six elements, while the other did not meet any of the six elements. For another eight providers, while the QSR reviewers found some deficiencies, they routinely did not identify all of the applicable concerns found in the sample review. That said, while DBHDS met the minimum requirements for the *Curative Action for Data Validity and Reliability* for this CI, DBHDS should consider undertaking some additional work to ensure that the IRR process is adequate. | |
| 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., | This CI was not met because the study could not confirm that any of 15 vendor-issued QIPs sufficiently addressed the quality improvement deficiencies and identified the needed remediation or need for technical assistance. While this sample size was small, the finding was universal. This called the QSR data for this CI into question.<br><br>Otherwise, DBHDS also used data collected from | 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*.<br><br>For Round 5 QSRs, Item 7 of the PQR requires the QSR reviewers to 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 also identification of providers in need of technical assistance. The sample review of provider and QSR documentation described above for CI 44.1 could not confirm that QSR reviewers were adequately identifying these opportunities for improvement. The study sampled 15 vendor-issued QIPs and found that none of the 15 fully addressed each of the identified deficiencies. This included two providers determined by the QSR reviewer to not require a QIP, but for whom the sample review found a QIP should have been required. While this sample size was small, the finding was universal. Therefore, this CI was not met because the study | 21st - Met*<br><br>**23rd - Not Met** |

| Compliance Indicator | Facts | Analysis | Conclusion |
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| links to on-line training material) and other assistance to assist the provider in improving its performance. | licensing reviews that identified DD providers with an approved CAP for licensing regulation *620.C.2*. | could not confirm that any of 15 vendor-issued QIPs sufficiently addressed the quality improvement deficiencies and identified the needed remediation or need for technical assistance.<br><br>DBHDS should implement training for QSR reviewers to ensure, and a supervisor methodology that confirms, that all vendor-issued QIPs sufficiently address the quality improvement deficiencies and identifies the needed remediation or need for technical assistance. This is consistent with other recommendations in this study that DBHDS should further evaluate the IRR for the QSR process.<br>... | |

**Attachment A: Interviews**

1. Heather Norton, Assistant Commissioner, Developmental Services
2. Dev Nair, Assistant Commissioner, Division of Quality Assurance and Governmental Relations
3. Katherine Means, Senior Director of Clinical Quality Management
4. Eric Williams, Director, Office of Provider Development
5. Jae Benz, Director, Office of Licensing
6. Taneika Goldman, Director, Office of Human Rights
7. Mackenzie Glassco, Associate Director of Quality and Compliance

**Attachment B: Documents Reviewed**

1. 2022 OL Annual Compliance Determination Chart
2. 2023 OL Annual Compliance Determination Chart
3. 12VAC35-105-160.C
4. 12VAC35-105-520.D
5. 29.4 Sample 160.E and 160.C Data Report:
6. Serious Incident Review and Root Cause Analysis Template (April 2023)
7. Individual Risk Tracking Tool (April 2023)
8. Instructional Video-Risk Tracking Tool (April 2023)
9. 29.16 IMU Look Behind Provider Notification 10.3.2023
10. 29.16 IMU Look Behind VCU Findings Report Q1 2023 RMRC 9.11.2023
11. 2016 RMRC Minutes 5.22.2023 Approved
12. RMRC Minutes 8.28.2023 draft
13. 09/11/2023 RMRC Meeting Minutes
14. CLB Look-Behind Report for Q3 and Q4 FY23
15. OHR Community Look-Behind Timeline
16. 30.4 520 Reviews 081623
17. Curative Action 30.7
18. "Minimizing Risk" Training Curriculum
19. "Initial Applicant Orientation" Training Curriculum
20. "Licensed Provider Coaching Seminar" Training Curriculum
21. Developmental Disabilities Care Concerns FY23 Summary
22. Sample Review Documents from 25 Licensed Provider Inspections Completed between 01/01/2023-06/30/2023:
    a. Root Cause Analysis Reports
    b. Annual Risk Management Plan
    c. Annual Quality Improvement Plan
    d. Policies, procedures, tools, and protocols relevant to the Quality Improvement Plan
    e. Annual Systemic Risk Assessment
    f. Minutes of meetings related to implementation of the Risk Management Plan
    g. Minutes of meetings related to implementation of the Quality Improvement Plan
    h. Root Cause Analysis Policy
    i. Two Root Cause Analysis investigation reports from each sample provider
23. Sample QSR Documents from 25 Licensed Providers
24. CONNECT Documents
    a. DW-0123-CHRIS Incident Report Level II Region 8.1
    b. CHRIS Export Interface Specification 7.13.23
    c. CHRIS Import Interface Specification 7.11.23
    d. CONNECT - CHRIS Data Transfer 6.9.23
    e. CONNECT O&M Plan Approved 05 04 2022
    f. Count of Providers and Services 6-27-2023
    g. Data Conversion Crosswalk - OLIS to CONNECT 7.3.23
    h. DW-0067-OHR Look-Behind 8.18.23
    i. DW-Connect-Service-Program Data 7.11.23
    j. Goal and Scope - Service to Diagnosis Project 5.23.23
    k. CONNECT O&M Plan
    l. RMRC Data Reporting Roadmap - Final 2022.02.07
    m. RMRC Roadmap Progress V4 8.18.23
    n. Service-Program Code Data 6-27-2023
    o. GL Solutions Final Contract, dated 11/16/1

p. CONNECT Actionable Recommendations, dated 7/18/23
q. CONNECT Actionable Recommendations Final -Detailed Response, dated 7/18/23
r. CONNECT AR Actionable Recommendations - Actions and Timelines

25. Process Documents and Attestations
    a. SIR by Type Surveillance Rates ANE VER004
    b. IMU Look-Behind VER003
    c. HR Process Document VER007
    d. Risk Awareness Tool Assessment VER 008
    e. Annual Dental Process VER 005
    f. Annual Physical Process VER005
    g. HCBS Setting Process Document VER002
    h. HR Process Document VER 004
    i. HR Process Document Free From ANE 29.23, Ver 005
    j. Process Document Individuals Protected from Injury VER 002
    k. HR Process Document 29.25 VER005, dated 6/20/23
    l. DD PRIORITY 1 VER 005
    m. ICF IID Admission Packet Reviews VER001
    n. PASRR- Data Collection VER001
    o. WaMS - Reports - SOP 7.2023.pdf
    p. LIC Asmt Incident Reprt Prov DS VER 005
    q. DOJ Process RM Requirements VER005
    r. Complex Needs Review Process Ver002
    s. DOJ Process QI Requirements VER004
    t. DOJ Process QSR Quality Improvement Program Findings VER001
    u. DOJ Process provider training policy Requirements VER002
    v. DD HOSP NOT VER 002
    w. DD Therapeutic Consultation BS Ver 005.pdf
    x. DS CSS St Hosp DD Verification Process VER 002
    y. DD CMSC VER 016 8.29.23
    z. DD Provider Data Summary VER 011 (8.17.23)
    aa. DD Provider Data Summary VER 012 (9.6.23)
    bb. QRT DS B1 QRT VER 001
    cc. QRT DS QRT VER 002
    dd. REACH Annual Report VER 001
    ee. Remediation of PP Deaths Process Document VER 003

26. DMAS Process Documents & Attestations
    a. B2 LOC Evaluation VER 002
    b. G6 Providers Review Medication Errors VER 002
    c. G8 Unauthorized Seclusion VER 002
    d. A3 Slot Assignment VER 001
    e. Annual Notification of Rights VER001
    f. Consumer Directed Employees VER003
    g. Contract Evaluation VER003
    h. Criminal Record Check VER003
    i. DBHDS Provider Memorandums VER001
    j. G2 Abuse and Neglect Prevalence VER 002
    k. NCQA Data VER003
    l. Orientation and Competencies VER003
    m. Plan Development VER003
    n. Provider Criteria VER00
    o. Provider Enrollment VER003

p. Service Facilitator Trng Requirements VER003
q. VIDES Choice Risk Assessments VER003
r. Waiver Claims VER003

27. QII Process Documents & Attestations
    a. NCI Validity & Reliability
    b. SIR by Type Surveillance Rates ANE VER004
    c. Annual Dental Process VER 005
    d. DOJ Process RM Requirements VER005
    e. COVLC REVIVE Training Overview 4.12.23
    f. COVLC REVIVE Training Process Ver 001 4.2023
    g. CY Apr Providers by Service.txt
    h. CY Apr Regional Providers.txt
    i. DBHDS MRO Process Document Final Feb2023
    j. DD CMSC VER 016 8.29.23
    k. ECT QII VER 002
    l. ISP Compliance QII VER 001 (8.11.23) final
    m. LevelsTiersMacro.txt
    n. OCQM QSR Vendor Methodology Ver 004 Final
    o. Process Document OHR Annual Seclusion and Restraint Reporting QII VER 002
    p. Provider Designation QII VER 002(8.27.23)
    q. RAT TO ISP QII VER 002 (8.27.23) final
    r. RQCs 1&5 QIIs VER 001-DOJ Process Document 8 4 23
    s. SC Retention QII VER 001 (8.11.23) final (2)
    t. Verification SOP 4.29.2021
28. PMI Process Documents and Attestations
    a. DS CSS Identification of Community Residences Process VER 005
    b. Transportation VER 002
    c. DOJ Process TRANSPORTATION NON NEMT THROUGH QSR PCR VER005
    d. DOJ Process Non NEMT Through QSR PCR VER008
    e. SIR by Type Surveillance Rates ANE VER004
    f. Annual Physical Process VER005
    g. DOJ Process RM Requirements VER005
    h. DD CMSC VER 016 8.29.23
    i. DOJ Process QI Requirements VER004
    j. DD Provider Data Summary VER 011 (8.17.23)
    k. DS Provider Reporting Measure CI PMI VER 002
    l. DS Stability Employment Measure VER003
    m. Provider Reporting Measure Process- HSAG Initiated
    n. Remediation of PP Deaths Process Document VER 003
    o. LIC Asmt Incident Reprt Prov DS VER 005
    p. DSP COMP VER 005
    q. DD REACH Emp training MC CEPP VER 003
29. Selected QII Toolkits
30. SFY24 QII Tracking Updated 8.22.23
31. Approved QIC Minutes and Materials for 9/2022 – 9/2023, including quarterly reports from the CMSC, RMRC, RQCs, MRC and KPA Workgroups
32. RMRC Task Calendar and Charter Tasks
33. SFY 23 RMRC QIC Subcommittee Work Plan
34. SFY 24 RMRC QIC Subcommittee Work Plan
35. RMRC Meeting Minutes and Materials, 9/2022-10/2023, including ILMU, ANE and Serious Incident presentations

36. Selected CMSC, MRC, RQC and KPA Workgroup Meeting Minutes and Materials, dated 9/2022 -8/2023
37. RMRC Program Description SFY24
38. Curative Action for Data Validity and Reliability, 1/21/22
39. Developmental Disabilities Quality Management Plan State Fiscal Year 2024, dated 8/13/23
40. Departmental Instruction 316 (QM) 20 Quality Improvement, Quality Assurance and Risk Management for Individuals with Developmental Disabilities
41. Quality Service Reviews (QSRs) and National Core Indicators (NCI) Policy & Procedure
42. 29.19.Summary 23rd Review
43. Provider Data Summary State Fiscal Year May 2023, dated 9/15/23
44. Supplemental Crisis Report FY23 Q1-Q4
45. FY2023 Support Coordination Quality Review Final Report, October 13, 2023
46. CHRIS Level II report dated in August 2023
47. Medicaid Home and Community-Based Services Settings Regulations Corrective Action Plan for the State of Virginia, approved by CMS effective 6/20/23
48. Developmental Disabilities Annual Report and Evaluation State Fiscal Year 2022, dated February 17, 2023
49. Office of Integrated Health Annual Physical and Dental Exams, dated 8/24/23
50. 29.26 Progress and revisions 8.2023
51. Summary of 30.11
52. DBHDS spreadsheet, 1/10/23 through 6/30/23, showing 117 inspections for which the provider had been determined to be non-compliant with risk management requirements
53. DBHDS spreadsheet, 1/1/23 through 6/30/23, showing providers that had been determined to be non-compliant with requirements about training and expertise for staff responsible for the risk management function and providers that have been determined to be non-compliant with requirements about conducting root cause analyses
54. Provider CAPs for #46 and #47
55. 42.3_42.4_Summary of Compliance
56. Appendix H for each of the HCBS Waivers
57. QRT SFY22 EOY Report
58. Case Management Steering Committee Semi-Annual Reports State Fiscal Year 2023 3rd and 4th Quarters, dated 9/8/23
59. Data Quality Monitoring Plan Source System Report, dated 9/28/23, and accompanying reports
60. QSR External Data Validation Checklist on 3/1/23
61. OCQM Quality Committees Policy & Procedure, effective 2/9/22
62. 36.08 Complex Needs Review, dated 8/23/23
63. PMI Development and Annual Review Processes, revised 6/29/23
64. SFY24 KPA Workgroups Schedule with Surveillance Data Requirements, updated 8/15/23
65. RQC Quality Improvement Committee Reports for SFY22 Q4 and SFY23 Q1-Q4
66. 8/27/23 DBHDS memorandum to providers of developmental disability services describing expectations regarding provider risk management programs and provider reporting measures
67. Quality Improvement Plan QSR Review Summary R4 and R5
68. VA 2023 QSR PQR Tool R5 F1 2.21.23.
69. PQR Tool and Evaluation Criteria March 2023
70. QIP Template VA R5 2023 QSR 4.6.23
71. VA 2023 QSR Round 5 Aggregate Report Final 081523
72. Quality Improvement Plan QSR Review Summary R4 and R5

# APPENDIX L

## Public Reporting

**by**

**Rebecca Wright, MSW, LICSW**

## Public Reporting 23rd Period Study

The Settlement Agreement in U.S. v. Commonwealth of Virginia requires the Commonwealth to make available information on the availability and quality of services in the community and to maintain sufficient records to document that the requirements of this Agreement are being properly implemented. 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 (CIs) 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 following CIs incorporate Public Reporting requirements:

**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 IX.C:** the Commonwealth will maintain sufficient records to document that the requirements of this Agreement are being properly implemented and shall make such records available to the Independent Reviewer for inspection and copying upon request and on a reasonable basis.

### Study Methodology

For this 23rd Period review, the study served as a follow-up to previous studies that have been competed annually since 2017 regarding the status of the Commonwealth's achievements regarding these requirements. For the 23rd Period reviews, the Parties have agreed to target the CIs that have not been Met twice consecutively in the two most recent reviews. The CIs for Provisions V.D.6 and IX.C were last studied in the 21st Period. The table below illustrates the compliance status for each of the applicable CIs to be studied during this 23rd Period:

| Provision | CIs studied in the 23rd Period | Two most recent ratings (i.e., M, M* or NM) |
|---|---|---|
| V.D.6. | 41.1 – 41.4 | NM-M* |
| | 41.5 | NM-NM |
| IX.C | 54.1 – 54.4 | NM-NM |

This study sought to gather and investigate facts and verify data and documentation provided by the Commonwealth to assess the sufficiency of the Commonwealth's actions to achieve and sustain achievement with each of the CIs described above. The methodology included 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, and verification that Virginia's relevant Process Documents and Attestations are complete. Evidence gathering included a review of the information available at the Settlement Agreement Library Site and the DBHDS website and on documentation DBHDS provided to describe the improvements they made since the 21st Period.

### Summary of Findings

**V.D.6:** By making most required data and reporting available to the public on the DBHDS website and/or the Settlement Agreement Library website, and because those data were sufficiently valid and reliable, the Commonwealth met the overall requirements for all of the CIs for this Provision. Still, as further described with regard to Provision IX.C below, DBHDS continued to need to make enhancements so that the public could more easily access the information.

**IX.C:** This study found that the Commonwealth met all of the related CIs, and for the first time. As of 8/25/23, the *Record Index Reference Tool* (i.e., the tool previously known as the Library Record Index) is available on the Library Record Index page. In addition to developing several other processes and tools, DBHDS developed a Process Document entitled *Settlement Agreement Library Protocol VER 002*, dated 6/27/23. This document provides a glossary of terms and describes roles and responsibilities for ensuring that the *Record Index Reference Tool* and the parent pages (i.e., the primary webpages specific to the alphanumeric filing references of the Settlement Agreement) are updated at least semiannually and that the various reports are updated according to their due dates. It also specifies the retention schedule for documents on the Settlement Agreement Library (i.e., 10 years.)

As described with regard to CI 42.5, most documents were timely and could be accessed on the Library Site, but the site was not intuitive and often required the viewer to have a level of prior knowledge about a report to access it with ease. This concern even extended to the *Record Index Reference Tool itself*. The Library Site does not have an easily visible tab on the Welcome page to access this tool or even clearly indicate that it exists. While the *Record Index Reference Tool* is well constructed and helpful, many public users might never reach it. DBHDS should consider making this tool more clearly visible.

The table below summarizes the findings for each of the applicable CIs.

| 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** |
| 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. | **Met** |

| V.D.6 Compliance Indicators | Status |
|---|---|
| Case Management Steering Committee Report, Risk Management Review Committee Report e. Annual Mortality Review Report, including Quality Improvement Initiatives stemming from mortality reviews f. Quality Management Program Evaluation g. Planned quality improvement initiatives metrics h. Quality Improvement initiatives metrics employed i. Key Accomplishments of the Quality Management Program j. QI Committee, workgroup and council challenges, including positive and negative outcomes and/or performance measure indicators outcomes that differ materially from expectations. Challenges, including positive and negative outcomes and/or indications that performance is below expectations. k. Committee Performance l. A summary of areas reviewed by the Regional Quality Councils, along with recommendations and any strategies employed for quality improvement m. A summary of areas reviewed by the DBHDS Quality Improvement Committee (QIC), along with gaps identified, recommendations, and any strategies employed for quality improvement n. Recommendations and strategies for related improvement | |
| 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. | **Met** |

| IX.C Indicators: | Status |
|---|---|
| 54.1 The Commonwealth maintains a written index that identifies the records sufficient to document that the requirements of the Settlement Agreement are being implemented and the entities responsible for monitoring and ensuring that the records are made available ("Record Index"). | **Met** |
| 54.2 The Record Index specifies the following components for each record: Identification and documentation of record locations; Timeframe for collecting and updating records as specified in the Settlement Agreement or as determined by DBHDS; Identification of a custodian of the records who is responsible for oversight of the collection, storage, and updates; A process to monitor/audit record completion. | **Met** |
| 54.3 The Record Index and all associated documents are timely available to the Independent Reviewer upon request. | **Met** |
| 54.4 Records will be maintained in accordance with applicable Library of Virginia Records Retention and Disposition Schedules or longer, as necessary to demonstrate compliance with the Settlement Agreement. | **Met** |

## V.D.6 Analysis of 23rd 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. | Overall, DBHDS fulfilled the requirements of this Indicator.<br><br>For this review, DBHDS provided a *Provider Data Summary Semi-Annual Report State Fiscal Year 2023, May 2023.* It was issued 9/15/23. 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.<br><br>With regard to data validity and reliability, DBHDS provided Process Document entitled *Provider Data Summary State Fiscal Year May 2023Ver 012*, | For this review, DBHDS provided a *Provider Data Summary Semi-Annual Report State Fiscal Year 2023, May 2023.* It was issued 9/15/23. 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:<br>• Data continues to indicate an annual 2% increase in the overall DD waiver population receiving services in the most integrated settings<br>• 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<br>• The Data Summary indicates an increase in services available by locality over time<br>• 95% of provider agency staff meet provider orientation training requirements<br>• 95% of provider agency direct support professionals (DSPs) meet competency training<br>• Requirements<br>• At least 95% of people receiving services/authorized representatives participate in the development of their own service plan<br>• At least 75% of people with a job in the community chose or had some input in choosing their job<br>• At least 86% of people receiving services in residential services/their authorized representatives choose or help decide their daily schedule<br>• At least 75% of people receiving services who do not live in the family home/their authorized representatives chose or had some | 21st Met*<br><br>**23rd - Met** |

| Compliance Indicator | Facts | Analysis | Conclusion |
|---|---|---|---|
| | dated 9/15/23. The Data Set Attestation dated 8/30/23 was sufficient for this CI, since *Version 012* did not make any changes to the relevant calculation or mitigation strategies. | input in choosing where they live<br>• 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<br><br>With regard to data validity and reliability, DBHDS provided Process Document entitled *Provider Data Summary State Fiscal Year May 2023Ver 012*, dated 9/15/23. The Data Set Attestation dated 8/30/23 was sufficient for this CI, since *Version 012* did not make any changes to the relevant calculation or mitigation strategies. | |
| 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 | Overall, DBHDS fulfilled the requirements of this Indicator.<br><br>For this review, DBHDS provided a *Provider Data Summary Semi-Annual Report State Fiscal Year 2023, May 2023.* It was issued 9/15/23. The report provided the demographics required by this CI.<br><br>With regard to data validity and reliability, DBHDS provided Process Document entitled *Provider Data Summary State Fiscal Year May 2023Ver 012*, dated 9/15/23. The Data Set Attestation dated 8/30/23 was sufficient for this CI, since *Version 012* did not make any changes to | For this review, DBHDS provided a *Provider Data Summary Semi-Annual Report State Fiscal Year 2023, May 2023.* It was issued 9/15/23. The report provided the demographics required by this CI.<br><br>With regard to data validity and reliability, DBHDS provided Process Document entitled *Provider Data Summary State Fiscal Year May 2023Ver 012*, dated 9/15/23. The Data Set Attestation dated 8/30/23 was sufficient for this CI, since *Version 012* did not make any changes to the relevant calculation or mitigation strategies. | 21st – Met*<br><br>**23rd - Met** |

| Compliance Indicator | Facts | Analysis | Conclusion |
|---|---|---|---|
| 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. | the relevant calculation or mitigation strategies. | | |
| 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 | Overall, DBHDS fulfilled the requirements of this Indicator.<br><br>For this review, DBHDS provided a *Provider Data Summary Semi-Annual Report State Fiscal Year 2023, May 2023.* It was issued 9/15/23. The report provided the demographics required by this CI.<br><br>With regard to data validity and reliability, DBHDS provided Process Document entitled *Provider Data Summary State Fiscal Year May 2023Ver 012*, dated 9/15/23. The Data Set Attestation dated 8/30/23 was sufficient for this CI, since *Version 012* did not make any changes to | For this review, DBHDS provided a *Provider Data Summary Semi-Annual Report State Fiscal Year 2023, May 2023.* It was issued 9/15/23. The report provided the demographics required by this CI.<br><br>With regard to data validity and reliability, DBHDS provided Process Document entitled *Provider Data Summary State Fiscal Year May 2023Ver 012*, dated 9/15/23. The Data Set Attestation dated 8/30/23 was sufficient for this CI, since *Version 012* did not make any changes to the relevant calculation or mitigation strategies. | 21st – Met*<br><br>**23rd - Met** |

| Compliance Indicator | Facts | Analysis | Conclusion |
|---|---|---|---|
| | the relevant calculation or mitigation strategies. | | |
| 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 | Overall, DBHDS fulfilled the requirements of this Indicator.<br><br>For the 23rd Period, DBHDS issued a *Developmental Disabilities Annual Report and Evaluation State Fiscal Year 2022,* on 2/17/23. This most recent version again included information for all the topics defined in the compliance indicator.<br><br>With regard to data validity and reliability, as described above for CI 36.1 above, overall, DBHDS has at least minimally implemented the requirements of the *Curative Action for Data Validity and Reliability*. | For the 23rd Period, DBHDS issued a *Developmental Disabilities Annual Report and Evaluation State Fiscal Year 2022,* on 2/17/23. This most recent version again included information for all the topics defined in the compliance indicator.<br><br>With regard to data validity and reliability, as described above for CI 36.1 above, overall, DBHDS has at least minimally implemented the requirements of the *Curative Action for Data Validity and Reliability*. | 21st – Met*<br><br>**23rd - Met** |

| Compliance Indicator | Facts | Analysis | Conclusion |
|---|---|---|---|
| initiatives metrics h. Quality Improvement initiatives metrics employed i. Key Accomplishments of the Quality Management Program j. QI Committee, workgroup and council challenges, including positive and negative outcomes and/or performance measure indicators outcomes that differ materially from expectations. Challenges, including positive and negative outcomes and/or indications that performance is below expectations. k. Committee Performance l. A summary of areas reviewed by the Regional Quality Councils, along with recommendations and any strategies employed for quality improvement m. A summary of areas reviewed by the DBHDS Quality Improvement Committee (QIC), along with gaps identified, recommendations, and any strategies employed for quality improvement. Recommendations and | | | |

| Compliance Indicator | Facts | Analysis | Conclusion |
|---|---|---|---|
| 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 | Overall, DBHDS fulfilled the requirements of this Indicator.<br><br>For this 23rd Period, Based on a review of the Library Site or the DBHDS website during this 23rd Period review, searches produced most of the specific information required by this CI.<br><br>For the 23rd Period review, as described in more detail with regard to Provision IX.C below, between October 2022 through August 2023, DBHDS undertook a multi-phase project to assess the Library and make improvements.<br><br>Still, while DBHDS provided a document with links to most of the reports and information for this study, without the benefit of the links, it remained difficult at times to locate pertinent documents. DBHDS continued to need | 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 with regard to CI 41.1, the protocol described the requirements for maintaining and updating the Library site at http://dojsettlementagreement.virginia.gov/. DBHDS had not updated the protocol at the time of the 21st Period review. The protocol 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.<br><br>However, at the time of the 19th Period and 21st Period reviews, a number of the designated reports for CI 41.5 at the Library site and/or DBHDS website were still not available or were outdated on the Library site. In addition, it was notable, that during these previous study periods, the consultant often found it difficult to locate documents on the Library Site or the DBHDS website. There was 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. The 21st Period review recommended that DBHDS should conduct an analysis of its websites and make modifications to simplify the process. For the 23rd Period review, as described in more detail with regard to Provision IX.C below, between October 2022 through August 2023, DBHDS undertook a multi-phase project to assess the Library and make improvements.<br><br>For this 23rd Period, Based on a review of the Library Site or the DBHDS website during this 23rd Period review, searches produced most of the specific information required by this CI. The exceptions included the following:<br>• The *Integrated Residential Services Report*, which was not located on the Library Site under the Integrated Living Options tab and or found on the DBHDS website. A link provided by DBHDS opened a data report described as residential settings by size and type as defined by the *Integrated Residential Services Report*, but not the report itself. Another link for the *Integrated Residential Services Report* was titled *HCBS Residential Settings Report,* but it was the same data report accessed with the first link. | 21st - Not Met<br><br>**23rd - Met** |

| Compliance Indicator | Facts | Analysis | Conclusion |
|---|---|---|---|
| Report k. DBHDS Annual Report l. National Core Indicators Annual Report and Bi-Annual National Report. | to make enhancements so that the public could easily access information. As further described below with regard to CI 52.3 below, as of 8/25/23, a *Record Index Reference Tool* is available on the Library Site, but the site does not have an easily visible tab on the Welcome page to access this tool or even clearly indicate that it exists. While it is well constructed and helpful, many public users might never reach it. DBHDS should consider making this tool more clearly visible.<br><br>With regard to data validity and reliability, DBHDS provided Process Document entitled *Provider Data Summary State Fiscal Year May 2023 Ver 012*, dated 9/15/23. The Data Set Attestation dated 8/30/23 was sufficient for this CI, since *Version 012* did not make any changes to the relevant calculation or mitigation strategies.<br><br>As described above for CI | • The most current version of the *Provider Data Summary (*i.e., *Provider Data Summary Semi-Annual Report State Fiscal Year 2023, May 2023*, issued on 9/15/23).<br><br>Still, DBHDS continued to need to make enhancements so that the public could easily access information. As further described below with regard to CI 52.3 below, as of 8/25/23, a *Record Index Reference Tool* is available on the Library Site, but the site does not have an easily visible tab on the Welcome page to access this tool or even clearly indicate that it exists. While it is well constructed and helpful, many public users might never reach it. DBHDS should consider making this tool more clearly visible.<br><br>In addition, for this study, DBHDS provided a document with links to most of the reports and information; however, without the benefit of the links, it remained difficult at times to locate pertinent documents. For example, in addition to difficulty finding the *Integrated Residential Services Report,* as described above, DBHDS provided a link to the DBHDS Annual Reports on the DBHDS website "Newsroom Page," but without the benefit of the link, this was not self-evident, or searchable, on the DBHDS website. In another example, on the DBHDS website, to access information about NCI results for the Commonwealth, one would have to know to first select Clinical and Quality Management from Offices, then choose OCQM. The OCQM page includes a button for NCI. That page further directs the viewer to the off-site NCI website; once there, the viewer would need to choose Survey Reports & Insights to be taken to a page where the Virginia reports can be accessed by scrolling down the page and selecting Virginia. On the other hand, the links document DBHDS provided for this study takes one directly to the Survey Reports & Insights page.<br><br>With regard to data validity and reliability, DBHDS provided Process Document entitled *Provider Data Summary State Fiscal Year May 2023 Ver 012*, dated 9/15/23. The Data Set Attestation dated 8/30/23 was sufficient for this CI, since Version 012 did not make any changes to the relevant calculation or mitigation strategies. As described above for CI 36.1 above, overall, DBHDS has at least minimally implemented the requirements of the *Curative Action for Data Validity and Reliability*. | |

| Compliance Indicator | Facts | Analysis | Conclusion |
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| | 36.1 above, overall, DBHDS has at least minimally implemented the requirements of the *Curative Action for Data Validity and Reliability*. | | |

**Section IX.C. The Commonwealth shall maintain sufficient records to document that the requirements of this Agreement are being implemented properly**

| Compliance Indicator | Facts | Analysis | Conclusion |
|---|---|---|---|
| 54.1: The Commonwealth maintains a written index that identifies the records sufficient to document that the requirements of the Settlement Agreement are being implemented and the entities responsible for monitoring and ensuring that the records are made available ("Record Index"). | As of 8/25/23, the *Record Index Reference Tool* (i.e., the tool previously known as the *Library Record Index*) is available on the Library Record Index page.<br><br>In addition to developing several other processes and tools, DBHDS developed a Process Document entitled *Settlement Agreement Library Protocol VER 002*, dated 6/27/23. This document provides a glossary of terms and describes roles and responsibilities for ensuring that the *Record Index Reference Tool* and the parent pages (i.e., the primary webpages specific to the alphanumeric filing references of the Settlement Agreement) are updated at least semiannually and that the various reports are | Previous reports found that DBHDS developed two documents that described the protocols for maintenance of the Library Record Index. These included the *Settlement Agreement Library Record Index* and the *DOJ Settlement Agreement Library Protocol*, both of which were effective on June 30, 2020. As of the 21st Period, DBHDS did not provide any additional protocols or any updates.<br><br>As reported previously, based on the *Settlement Agreement Library Record Index*, the purpose of the Library Record Index is to identify the records sufficient to document that the requirements of the Settlement Agreement are implemented, as well as the entities responsible for monitoring. Consistent with the requirements of CI 54.01, the *Settlement Agreement Library Record Index* and the *DOJ Settlement Agreement Library Protocol* indicated the Library Record Index will catalogue all documents posted to the Library (http://dojsettlementagreement.virginia.gov/) and will specify the business owner or Subject Matter Expert (SME) responsible for the origination and update of the record. The *Settlement Agreement Library Record Index* also stated that the business owner of the Library overall is the DBHDS Settlement Agreement Coordinator. In addition, at that time DBHDS did not provide a Library Record Index nor was one found at the on-line Library site. Further, pursuant to the findings for CI 41.05, many of the required reports and documents were not available or were outdated.<br><br>For this 23rd Period, DBHDS provided a summary document entitled *Settlement Agreement Document Library: Improvement Activities 8.2023*. This document provided extensive detail about the phases of improvement activities and results of those activities from October 1, 2022 through August 2023. The document described activities and resulting outcomes, including project initiation and planning as well as four distinct project phases. During the project initiation and planning | 21st - Not Met<br><br>**23rd - Met** |

| Compliance Indicator | Facts | Analysis | Conclusion |
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| | updated according to their due dates.<br><br>. | phase, the document indicated that the Project Manager reviewed the previous *Library Record Index* and the previous D*OJ Settlement Agreement Library Protocol* and found both of the documents to be incomplete and requiring updates. Across the course of the project, DBHDS completed updates to both and submitted them as evidence for this review. In addition to developing several other processes and tools, DBHDS developed a Process Document entitled *Settlement Agreement Library Protocol VER 002*, dated 6/27/23. This document provides a glossary of terms and describes roles and responsibilities for ensuring that the *Record Index Reference Tool* (i.e., the tool previously known as the *Library Record Index*) and the parent pages (i.e., the primary webpages specific to the alphanumeric filing references of the Settlement Agreement) are updated at least semiannually and that the various reports are updated according to their due dates.<br><br>As of 8/25/23, the *Record Index Reference Tool* (i.e., the tool previously known as the *Library Record Index*) is available on the Library Record Index page. | |
| 54.2 The Record Index specifies the following components for each record: • Identification and documentation of record locations • Timeframe for collecting and updating records as specified in the Settlement Agreement or as determined by DBHDS Identification of a custodian of the records who is responsible for oversight of the collection, storage, and updates • A process to monitor/audit record completion. | As described for CI 54.2, as of 8/25/23, the *Record Index Reference Tool* is available on the Library Record Index page. For 42 distinct reports, it specifies the parent page, the frequency and the due date for when each report would be due to be posted to the Library.<br><br>As also described for CI 54.2, a Process Document entitled *Settlement Agreement Library Protocol VER 002*, describes roles and responsibilities for ensuring that the *Record* | As described for CI 54.2, as of 8/25/23, the *Record Index Reference Tool* (i.e., the tool previously known as the *Library Record Index*) is available on the Library Record Index page. For 42 distinct reports, it specifies the parent page, the frequency and the due date for when each report would be due to be posted to the Library.<br><br>As also described for CI 54.2, a Process Document entitled *Settlement Agreement Library Protocol VER 002*, describes roles and responsibilities for ensuring that the *Record Index Reference Tool* and the parent pages (i.e., the primary webpages specific to the alphanumeric filing references of the Settlement Agreement) are updated at least semiannually and that the various reports are updated according to their due dates.<br><br>In addition, the *Settlement Agreement Document Library: Improvement Activities 8.2023* described the processes to monitor/audit record completion. These are also formalized in the *Settlement Agreement Library Protocol VER 002.* DBHDS submitted several other documents that provide additional detail about the processes, (e.g., *SA Library Parent and Reporting Page Kanban Board Instruction*, *August 2023 Broken Link Report,* etc.*)* | 21st - Not Met<br><br>**23rd - Met** |

| Compliance Indicator | Facts | Analysis | Conclusion |
|---|---|---|---|
| | *Index Reference Tool* and the parent pages (i.e., the primary webpages specific to the alphanumeric filing references of the Settlement Agreement) are updated at least semiannually and that the various reports are updated according to their due dates.<br><br>The *Settlement Agreement Document Library: Improvement Activities 8.2003* described the processes to monitor/audit record completion. These are also formalized in the *Settlement Agreement Library Protocol VER 002.* | | |
| 54.3 The Record Index and all associated documents are timely available to the Independent Reviewer upon request. | For this 23rd Period, as described with regard to CI 54.2, as of 8/25/23, the *Record Index Reference Tool* (i.e., the tool previously known as the *Library Record Index*) is available on the Library Record Index page. For 42 distinct reports, it specifies the parent page, the frequency and the due date for when each report | At the time of the 21st Period review, many required documents were not posted to the Library site. In interview, DBHDS staff acknowledged to the Independent Reviewer that this was an area of deficiency.<br><br>For this 23rd Period, as described with regard to CI 54.2, as of 8/25/23, the *Record Index Reference Tool* (i.e., the tool previously known as the *Library Record Index*) is available on the Library Record Index page. For 42 distinct reports, it specifies the parent page, the frequency and the due date for when each report would be due to be posted to the Library. It also provides an active link for each of the 42 reports as well as the Welcome page. As described with regard to CI 42.5 above, most documents were timely and could be accessed on the Library Site, but the site was not intuitive and often required the viewer to have a level of prior knowledge about a report to access it with ease. | 21st - Not Met<br><br>**23rd - Met** |

| Compliance Indicator | Facts | Analysis | Conclusion |
|---|---|---|---|
| | would be due to be posted to the Library. It also provides an active link for each of the 42 reports as well as the Welcome page.<br><br>As described with regard to CI 42.5 above, most documents were timely and could be accessed on the Library Site. While this met the requirements for the CI overall, it remains notable that the site is not intuitive and often required the viewer to have a level of prior knowledge about a report to access it with ease.<br><br>This concern even extended to the *Record Index Reference Tool* itself. The Library Site's Welcome page did not provide a clearly visible means to access this tool or even clearly indicate that it exists. | This concern even extended to the *Record Index Reference Tool* itself. When viewed using the Safari web browser, the Library Site does not have a tab on the Welcome page to access this tool or even clearly indicate that it exists. To locate the tool, one would need to scroll far down on the Welcome page to Section IX. Implementation of the Agreement and click on "The Commonwealth shall maintain sufficient records to document that the requirements of this Agreement are being properly implemented and shall make such records available to the Independent Reviewer for inspection and copying upon request and on a reasonable basis" to be taken to the Library Index page. From there, one can then download the *Record Index Reference Tool.* Based on interview with DBHDS staff, it appeared there was such a tab on a pop-up menu when using Chrome or Edge browsers. However, the fact remained that accessibility to the *Record Index Reference Tool* was limited. While it is well constructed and helpful, many public users might never reach it. DBHDS should consider making this tool more clearly visible. | |
| 54.4: Records will be maintained in accordance with applicable Library of Virginia Records Retention and Disposition Schedules | For this 23rd Period review, the Commonwealth met the criteria for this CI. The *Settlement Agreement Library* | Based on findings from previous studies, both the *Settlement Agreement Library Record Index* and the *DOJ Settlement Agreement Library Protocol* stated that DBHDS would maintain records in accordance with applicable Library of Virginia Records Retention and Disposition Schedules, but provided no additional detail with regard to those expectations. The *DOJ Settlement Agreement Library Protocol* also | 21st - Not Met<br><br>**23rd - Met** |

| Compliance Indicator | Facts | Analysis | Conclusion |
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| or longer, as necessary to demonstrate compliance with the Settlement Agreement. | *Protocol VER 002* Glossary of Terms/Roles and Responsibilities clearly states that "Under Code of Virginia § 42.1-85, the Library of Virginia (LVA) has the authority to issue regulations governing the retention and disposition of state and local public records. In keeping with the Code's mandate, LVA has developed records retention and disposition schedules outlining the disposition of public records. The retention schedule for documents on the Settlement Agreement Library is 10 years." | described an archiving procedure, as follows:<br>"All documents posted in the Settlement Agreement Library at the time of initial launch will remain in the main body of the Library for six months. Following the initial six month period, all documents replaced by a new or revised document will be moved to the archive. For example, a new annual report will replace the previous annual report and the previous report will be moved to the archive. All records will remain in the archive and accessible to users in accordance with the applicable Library of Virginia Records Retention and Disposition Schedules."<br><br>For this 23rd Period review, the Commonwealth met the criteria for this CI. The *Settlement Agreement Library Protocol VER 002* Glossary of Terms/Roles and Responsibilities clearly states that "Under Code of Virginia § 42.1-85, the Library of Virginia (LVA) has the authority to issue regulations governing the retention and disposition of state and local public records. In keeping with the Code's mandate, LVA has developed records retention and disposition schedules outlining the disposition of public records. The retention schedule for documents on the Settlement Agreement Library is 10 years." | |

**Attachment A: Documents Reviewed**

1. Developmental Disabilities Annual Report and Evaluation State Fiscal Year 2022, on 2/17/23.
2. Provider Data Summary Semi-Annual Report State Fiscal Year 2023, May 2023
3. Provider Data Summary Process Document State Fiscal Year May 2023Ver 012, dated 9/15/23
4. Provider Data Summary Data Set Attestation, dated 8/30/23
5. Curative Action for Data Validity and Reliability
6. 41.1-41.5 Report Links
7. August 2023 Broken Link Report
8. Broken Links Review 11.2022
9. DOJ Document Library Update Form WAIVER SLOT ALLOCATION Blank Form
10. DOJ Document Library Update Form WAIVER SLOT ALLOCATION
11. Kanban Excel Export 8.2023
12. Library Kanban and Library Page Updates Form Screenshots 8.2023
13. Record Index Reference Tool 8.28.2023
14. SA Library Parent and Reporting Page Kanban Board Instructions
15. Settlement Agreement Document Library Improvement Activities 8.2023
16. Settlement Agreement Library Protocol VER 002, June 30, 2020
17. http://dojsettlementagreement.virginia.gov/
18. https://dbhds.virginia.gov

# APPENDIX M

## 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 Plan |
| BSPARI | Behavior Support Plan Adherence Review Instrument |
| 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 |
| CTA | Consultation and Technical Assistance |
| 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 |
| EHA | Office of Epidemiology and Health Analytics (formerly DQV) |
| 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 |
| IRR | Inter-rater Reliability |
| 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 |
| OSVT | On-Site Visit Tool |
| PASSR | Preadmission Screening and Resident Review |
| PCR | Person Centered Review |
| PCP | Primary Care Physician |
| PHA | Public Housing Authority |
| POC | Plan of Care |

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| 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 |
| RCA | Root Cause Analysis |
| 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 |