FY 2021 3rd Qtr. QRT Meeting Summary Meeting held 5/19/2021 (2nd Qtr)
Meeting Attendance (via Google Meet)
• Thren Baugh, QMR Supervisor Y or N
• Donna Boyce, DMAS Program Advisor Y or N
• Patricia Cafaro, DBHDS Mortality Review Program Clinical Manager Y or N
• Tracy Stith Harris, DMAS Contract Monitor Y or N
• Jennifer Kurtz, DBHDS Community Resource Consultant Y or N
• Taneika Goldman, DBHDS Director of Human Rights Y or N
• Jae Benz, DBHDS Director of Licensing Y or N
• Ann Bevan, DMAS Director of Developmental Services Y or N
• Deanna Parker, DBHDS Sr. DD Policy Analyst Y or N
• Jason Perkins, DMAS DD Program Manager Y or N
• Jenni Schodt, DBHDS Settlement Agreement Director Y or N
• Britton Welch, DBHDS Director Office of Community Quality Improvement Y or N
• Susan Moon, DBHDS Director of the Office of Integrated Health Y or N
• Dawn Traver, DBHDS Waiver Operations Director Y or N
• Patrick Buzzee-Penfold, DMAS Contract Monitor Y or N
• Katie Morris, DMAS HCBS Program Manager Y or N
• Andrew Greer, Sr. Policy Analyst Y or N
• Rupinder Kaur, DBHDS Data Analyst Y or N
• Maureen Kennedy, DBHDS SIS Manager Y or N

	Agenda Item	Meeting Discussion	
I	**Follow-up/ and global updates**		**Follow-up**
1.0	**Settlement Agreement Reporting**	The DOJ Settlement Agreement requires annual review of meeting charters. Substantive changes to the QRT process may not be made without advance review and agreement by the QRT, DMAS and prior approval by CMS. Accordingly, the charter has been reviewed in advance with several proposed changes based on the following rationale:	**Follow-up:** The timeframe for completion is ASAP (i.e., March 1st or by the court date 5/1). An additional consideration is completion of the EOY report and related stakeholder presentations (DS Council, VALIDD, QIC meeting, etc.)

		1) All QRT meeting documentation is now captured as part of the Settlement Agreement online library. Therefore, names of individual agency staff previously listed in the charter have been removed and replaced with the position titles. 2) Charter language has been updated to reflect the informal, consensus based decision making structure of the QRT. (removed voting, and quorum requirements) 3) The Charter has been uploaded to Box for review. In response to a request during the meeting the QIC reporting structure is not included in the committee charter, though this is outlined in detail in the DBHDS Quality Management Plan. Staff will follow up offline to determine if additional language is necessary.	
	2020 QRT EOY Report	Per the DOJ Settlement Agreement, The QRT is required to draft an annual report summarizing waiver performance, it must be posted to the DBHDS website and include a mechanism for CSB review and feedback on the report. The End of Year report has been drafted and sent to DBHDS Primary Data SME's by e-mail (5/13) with feedback requested by 5/20. The report and review tool are intended to be finalized for anticipated distribution to CSB's for their feedback on June 1st.	**Follow-up:** Corrections from SME's will be incorporated.
	Preview of QRT Interim Data Reporting Solution	For some time, the QRT has been reliant on manual processes for compiling and reporting data for review. Staff highlighted that a primary area of need for the QRT is modernization of its data collection processes and tools. This manual process does not allow for viewing of historical data, analysis of trends, or evaluation of the impact of any intervention implemented as remediation. For the past several months, DBHDS has been working with data analyst contractors to build an interim solution facilitating data entry into a tool that would	**Follow-up:** Contract team will review and discuss corrections to be made.

		collect and report QRT data as part of a single dataset to allow for this type of analysis. The interim automated solution is an excel tool at the back end that would be integrated with Tableau to allow visual presentation of data. The new tool also allows for all QRT information (including remediation reporting, to be captured in one tool instead of spread across multiple documents). This is hoped to be finalized for reporting 3rd quarter data queries. A long term data solution is also proposed which would adopt a similar structure of the new tool, but use sourced, aggregate data from all data SME's into REDCap (proposed). The Data Analyst introduced and walked through the tool and the committee viewed several draft Tableau dashboards with select data and visualizations that would be projected during meetings. • A Master Excel Data File is the source for the data tool which incorporates all of the same information from the QRT chart into columnar format with Tableau on the back end for data visualizations. • A standard dashboard has been created for use during meetings incorporating template data (PM's below compliance for the quarter, visual comparison to the previous quarter, other data elements may be pulled as needed for viewing and discussion during the meeting) • Permissions – The master data file is currently stored on the DBHDS server. There are 41 different PM's and 16 different data sources completed by multiple people so the tool will be created so that the data SME's only have to view and enter information for their own PM's (numerator denominator and for QMR, CAP data attached to PM, provider name and summary reason for CAP and, for the future long term data	

		solution data wish list (training and TA conducted, CAP closed in follow-up reporting). • Data entry format– The team is considering a form-based solution so that Data SME's can enter the data directly into the form thus reducing human error. • Data submitted by SME's will be available for a predetermined length of time to allow for corrections. The DBHDS Data Manager will review and approve submissions as final. Data will be updated each night for Tableau. Historical information will be archived in Tableau for future trend analysis. Following the meeting discussion, the following corrections will be made: • Measures below compliance should include only those measures below 86% (as opposed to 86/5 and below) • Viewable fields for data entry should encompass whole year versus side by side view • Fix 0% so that it does not automatically assign an error or "missing" data since 0/0 is a value for reporting and informational purposes. A question was asked whether or not the tool will include one large text box to add all of the remediation activities and CAP summaries versus separate columns (i.e. column with total# of CAPS, column with provider name, column with reason for CAP.) This will be brought back to the contract team for discussion.	
	CMS Evidentiary Reporting	The state is due for submission of its CMS Evidentiary Report which is an aggregation of three years' worth of data summarizing waiver performance under the waiver assurances. The team discussed information needed in preparation for drafting the report:	**Follow-up:** DMAS and DBHDS will communicate offline to follow up regarding expectations for the CMS Evidentiary Report. DBHDS will forward a crosswalk including the inconsistencies found in the FIS waiver application to DMAS for review and correction.

		• Is there a new/updated Evidence Report template or will the previous template be used? • What is the proposed due date for submission to DMAS **Discussion:** There are several things that may need to be addressed before final the report is submitted: • There are a few important inconsistencies between PM language in waiver application and what we are using in waiver assurance QA reporting for the QRT. • Individual Remediation Reporting to CMS For PM C4, C6, and C7, it appears that the Appendix G didn't get updated uniformly for all of the waiver applications, when we revised the waiver PM's in 2018. Some changes represent minor differences in wording but with at least one other PM, the difference in wording reflects a difference in what is to be measured within the PM. It was recommended that DMAS may need to look at other waivers so see if this is the same for all three applications. DBHDS will send the comparison chart to DMAS for possible updating. DMAS will also send a copy of the CCC plus waiver template and ask about the proposed timeline for submission of the evidentiary report.	
	G4: CMS Individual Remediation Reporting: s	See QRT First Quarter Meeting Summary in Box. **CMS Individual Remediation Reporting**: see QRT First Quarter Meeting Summary in Box. For this PM, QMR reviewers are looking for a copy of the ANE Client Rights form that has been signed annually by the individual for each service from a provider licensed by DBHDS and for those receiving CM services. For the providers cited,	**Follow-up:** With DMAS input, make a determination whether or not a compilation of TA activities will be sufficient to demonstrate individual remediation for the PM**.**

		DMAS recommended technical assistance in these vases versus a formal CAP. **Remediation:** If the form is unable to be produced, DMAS recommends delivery of technical assistance, but does not cite the provider. There is also no follow-up given with technical assistance. Licensing reviews providers under a single related Human Rights regulation (HR citation 150.4) which gives them authority to cite for a violation and completion of the CAP is monitored by Licensing. The remediation is that the provider participate in training within 15 business days. For the first time, this measure is below compliance for 2020. As a result, the state will need to prepare for individual remediation reporting in the CMS Evidentiary Report. It will not be possible to show individual remediation for this PM using the QMR data source outlined in the waiver application since QMR does not cite for this PM. Further, the Human Rights advocates citations given according to the regulation may not exactly match what QMR reviewers are expecting to see from providers. Therefore, even if the QRT is able to acquire an aggregate report counting completed Licensing CAPS in 2020 for this PM), we may actually be measuring apples and oranges After discussion, it was noted that DMAS could possibly capture TA delivered for the PM in 2020, though it might take some time to compile. DMAS will follow up to discuss internally whether or not a summary of 2020 TA activities delivered for the PM would be appropriate for individual remediation reporting for the CMS Evidentiary Report.	

2.0	**G7: QSR Contractor Alerts**	**N: Count of how many PCR alerts were issued to OHR that were NOT due to unauthorized restrictive interventions** **D: total # of PCR reviews.** For FY2020, DBHDS contracted with HSAG to conduct QSR reviews, replacing the previous Qlarant, the QSR contractor. Since this time, DBHDS has not viewed QSR data for QRT reporting. Beginning July 2020, HSAG conducted reviews of individuals receiving services from selected providers or CSBs for the most recent timeframe of July 1, 2019 through June 30, 2020 for support coordination and October 1, 2019 through March 31, 2020 for provider documentation. In addition to missing data for 2020 reporting, there is no updated documentation about the QSR process for the PCR alerts. Explanatory information about how the information is collected i.e., how the PCR alerts are defined (what are they, how are they sent to OHR, and why - are they based on a regulatory requirement, etc., how is the population defined (explanation of where the denominator originates from) and how are the alerts screened for those not due to unauthorized restrictive interventions is not available? Process documentation received does not incorporate this level of detail. As of the meeting date, QRT staff is still awaiting QSR data for inclusion in the EOY 2020 report and the CMS Evidentiary report due in the Fall.	**Follow-up: Update 4/12/2021**: QSR data is still unavailable. DBHDS is awaiting the final draft from HSAG. The QRT Manager will continue follow-up.

3.0	**NCQA Data**	NCQA (MCO) data that is used to capture the PM's G9 and G10 is still being compiled for FY 2020. This data is received and reported annually; however, there is QRT discussion from 2019 noting a plan to update this in the next waiver amendment.	**Update:** The MCO information was received and is now incorporated on the 4th Qtr. QRT chart.
II.	***Review and Discussion of 2nd Qtr. (10/1/2020-12/31/2021) QRT Data* (PM's with percentages reported below the 86% threshold for 2nd Quarter meeting).**		
C2	**Number & percent of licensed/certified waiver provider agency staff who have criminal background checks as specified in policy/regulation with satisfactory results.** For 2nd quarter BI waiver reporting, compliance was lower in this waiver than in others. This was also seen in first quarter data before the percentages for this waiver were recalculated. It was noted that CAPS included several staff with no record of employment in the provider file. The provider had been using people from out of state to fill in and provide support for individuals. After a request for the information, DMAS will research to determine the service in which the CAPS were issued. BI Waiver **23/30 (76.7%)** **<u>CAPS</u>** **2nd Quarter** – BI 2 CAPS • Bridges of Virginia – Only had VA State Police Sex Offender Registry search results, No Record of Employment • St Vincent Home – Provider stated it was an oversight **Remediation:**	**Follow-up:** This should continue to be included as an agenda item for the PRT. DMAS will double check the service for this CAP.

C5	**Number & percent of non-licensed/noncertified provider agency DSPs who have criminal background checks as specified in policy/regulation with satisfactory results.** Only the BI waiver is out of compliance for 2nd Qtr. 0/1 (0%) CL and FIS Waivers 100%. **CAPS** 2nd **Quarter** – BI 1 CAP Holistic Care Services – Was not provided after being requested by HCCSII **Remediation:** Continue to add this reminder in notices to providers. This should also be included as an agenda item for the Provider Roundtable (PRT).	**Follow-up:** A reminder should be sent to providers (provider list serve and PRT meeting) to include the results of background checks (does not have to be the actual documentation). Follow-up may be needed to discuss how this should be handled in manual guidance. Contact DMAS for updated information on provider CAPS.
C8	**Number and percent of provider agency staff meeting provider orientation training requirements.** **2nd Qtr. compliance BI 26/31 (83.9%)** **CAPS** ***BI 1 CAP*** • 1 CAP Bridges of VA – No record of employment, not present DMAS reported during the meeting, that for two of the largest providers, proficiency confirmed was not indicated. Members of the QRT discussed whether there was any authority to require providers to show us their remediation data so that we can monitor compliance using their own evidence. It was responded that there is no authority for the state to request remediation data from the provider. However, provider compliance monitoring and oversight is now allowable according to the regulation establishing mandatory training and TA and	**Follow-up:** QII implemented for provider orientation and competencies. The PM will continue to be reviewed for improvement. No further follow-up needed.

	would follow a statewide provider remediation process. The oversight is onducted by the CRC's who could develop a process to follow up with providers no more than 2x and then refer back to previous QMR reviews to look at the type of citations given. This work will need to be re-initiated with a transparent remediation and follow-up process to determine whether or not delivery of TA or training yields improvements in compliance. As in prior years, this PM will continue to be reported out of compliance. **Remediation:** As a quality improvement initiative to improve compliance with this PM, the Provider Development team is conducting Regional trainings on the orientation and competencies for providers with CAPS and inviting providers with CAPS to attend targeted trainings (see detailed update in PM #C9).	
C9	**Number and percent of provider agency direct support professionals (DSPs) meeting competency training requirements.** **2nd Qtr. compliance CL 41/107 (38.3%)*** **<u>CAPS</u>** ***CL 5 CAPS*** • Bridges of VA: Not present, no annual updates • Circle of Life: Annual update not completed • Eastern Shore CSB: Not dated, late, missing • New Beginning: Proficiency Confirmed was not checked • Region 10: Proficiency Confirmed not checked **Remediation:** The committee was updated about Regional Trainings being held across the state and a plan to train on the required orientation and competencies for those providers with recent CAPS in this area. The training is being conducted by our Provider Development team and part of a Regional Quality Council Quality Improvement Initiative (QII) to the QIC in an attempt to improve compliance with the orientation and competency PM's.	**Follow-up:** QII implemented for provider orientation and competencies. The PM will continue to be reviewed for improvement. *The state will also need to reinitiate work on the mandatory provider remediation process.*

	As the waiver regulations advance toward final status, the committee was reminded that another source of prospective remediation is the mandatory provider remediation process (new training and TA regulatory requirement). This work will need to be reinitiated. As in prior years, this PM will continue to be reported as out of compliance for 2020 on the EOY report.	
D1	**Number and percent of individuals who have Plans for Support that address their assessed needs, capabilities and desired outcomes.** 2nd Qtr. Compliance: CL 174/218 (79.8%), FIS 65/78 (83.3%) **<u>CAPS</u>** *CL 6 CAP*s - - • Begonia: sexually inappropriate behavior • Eastern Shore: Fall risk • Horizon Behavioral Health: Turning and positioning, behaviors, aggressive behavior, fall risk, allergies, seizures • New Beginning: Lifting and transferring turning and positioning and inappropriate sexual behavior not addressed in day support plan • St. Vincent Home: Constipation, ex. supports with protection from infectious diseases due to immune system impairment • Region Ten: Suicide prevention, turning and positioning, fall risks, seizures, SIB, inappropriate sexual behavior *FIS 3 CAPS* • Horizon Behavioral Health: Emotional outbursts, fall risks, special diet, property destruction, wandering • Region Ten: Seizure management, suicide prevention, special diet, inappropriate behaviors with children, turning and positioning, medical risks • St. Vincent's: Wandering, allergies, protection from infectious disease.	**Follow-up:** Add to the PRT agenda and provider list serv as reminders. *The state will also need to reinitiate work on the mandatory provider remediation process.*

	Remediation: This PM should continue to be added as a reminder in notices to providers. This should also be included as an agenda item for the PRT. See previous discussion in C9 regarding re-initiating the mandatory provider remediation process.	
D3	**Number and percent of individuals whose Plan for Supports includes a risk mitigation strategy when the risk assessment indicates a need.** 2nd Qtr Compliance: FIS 17/29 (58.6) **CAPS** *FIS 4 CAPS* • Horizon Behavioral Health: emotional outbursts, fall risks, wandering, special diet • Region Ten: seizures, SIB, suicide attempts, turning and positioning special diet • RSV: Property destruction • St. Vincent Home: wandering, use of epi pen, special diets, property destruction, assault **Remediation:** See previous discussion in C9 regarding re-initiating the mandatory provider remediation process.	**Follow-up:** Add to the PRT agenda and provider list serv as reminders. *The state will also need to reinitiate work on the mandatory provider remediation process.*
G4.	**Number and percent of individuals who receive annual notification of rights and information to report ANE.** **For 2nd Qtr. 2021,** See discussion in Section I of this summary. **Remediation:** See previous discussion in Section I.	**Follow-up:** The state will need to agree on what will be included in the Evidentiary Report as individual remediation for the PM. A smaller group will also need to be convened at a future date to develop a process to capture reporting for this PM to ensure that QMR and Human Rights are reviewing for the same thing.
G6	**Number and percent of licensed DD providers that administer medication that were not cited for failure to review medication errors at least quarterly** **2nd Qtr. compliance aggregate waivers (79%)**	**Follow-up:** Add to the PRT agenda and provider list serv as reminders. *The state will also need to reinitiate work on the mandatory provider remediation process.*

	A new DW report used for this measure counts licensed congregate settings owned by a provider under one license and one inspection. The new report was developed based on new priorities under the Settlement Agreement and replaces the previous report. **Remediation:** Citations include providers who did not review Med errors which are being captured according to the new regulatory interpretation outlined above.	
PM G9	**Number and percent of participants <u>20 and above</u> (G9) AND <u>19 and younger</u> (G10) who had an ambulatory or preventive care visit during the year.** **This PM is below threshold for 2020.** **G9 For 2nd Qtr. 2021, CL 7761/10726 (72.36%), FIS 1221/2251 (54.24%) BI 187/325 (57.54%)** **G10 For 2nd Qtr. 2021, CL 264/749 (35.25%), FIS 261/722 (36.15%) BI 1/2 (50%)** MCO aggregate information is reported annually by QRT. DOJ SA requires that remediation occur within 6 months of discovery. By the time that the QRT reviews the data at the end of the year, the DOJ SA required timeline for remediation has passed. Further, because the information is reported annually, how would remediation using the MCO data be done, as the QRT has limited control over the state MCO's? **Remediation:** The PM is still being reviewed to determine if more individuals are going to the doctor for preventive care, as the state has relaxed social distancing and mask guidelines.	**Follow-up:** The PM continues to be under review.
	New agenda items added None	