FY 2021 4th Qtr. QRT Meeting Summary for Qtr 3 Data
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
• Guest
• Guest

	Agenda Item	Meeting Discussion	
Introduction of new members and presenters			New and existing members
I.	**Follow-up/ and global updates**		**Follow-up**
1.0	**NEW: Waiver Operations QRT TEAMS folder**	It was reported that a dedicated TEAMS folder for QRT is now housed in TEAMS under a new Waiver Operations TEAMS site which will also house the Contract Management Operations files.	**Follow-up:** N/A

		The use of Box for QRT has been discontinued. Documents moved and uploaded to TEAMS represent 2018-present. The other historical information will be moved over in the near future. The primary focus is the overall set up of the TEAMS folder structure and assigning appropriate permissions. The link to access the site will be forwarded when this initial work has been completed.	
2.0	**Mandatory Provider Remediation**	DBHDS and DMAS have reinitiated the work to finalize processes for mandatory provider remediation now permissible under the new DMAS DDW regulations. A basic structure and protocol has been established in a draft guidance document but it still needs some remaining work before being operationalized. Staff from both agencies met last week on the 12th and have developed a plan to move forward. It is intended that mandatory remediation will be a last resort process for providers challenged with persistent low compliance with the waiver-related regulations, since as a state we now have the authority to take negative action against providers who do not participate in mandated remediation. The regulatory language is included on the agenda and the link to the regulations is and in the third column. 12VAC30-122-120. Provider requirements. D. Providers with a history of noncompliance, which may include (i) multiple records with citations of failure to comply with regulations; (ii) multiple citations related to health and welfare for one support plan; or (iii) citation by either DMAS or DBHDS in key identified areas, resulting in a corrective action plan or citation will be required to undergo mandatory training and technical assistance in the specific areas of noncompliance as part of a corrective action plan. These areas of noncompliance may include health, safety, or failure to address the identified	https://law.lis.virginia.gov/admincode/title12/agency30/chapter122/section120/

		needs of the individual. Failure to comply with any areas in the corrective action plan shall result in referral to DMAS Program Integrity and initiation of proceedings related to termination of the provider Medicaid participation agreement.	
3.0	**Update: Settlement Agreement Reporting**	Settlement Agreement updates: • The DOJ Settlement Agreement requires annual review of meeting charters. The updated 2021 QRT meeting charter was forwarded for inclusion in the new DOJ/SA materials for review by the QIC. • DBHDS continues to discuss how to address process documentation and data reliability and validation requirements resulting from the DOJ Settlement Agreement. • The DOJ IR 19th period draft study proposal for the quality and risk management study was received by DBHDS.	**Follow-up:** N/A
4.0	**QRT Interim Automated Data Reporting Solution Demonstration (Power Apps Integration)**	During the last QRT, meeting, an interim automated QRT data solution was demonstrated that would help capture historical information, analyze trends in the data over time, produce summary dashboard data, customized reports via query, as well as visualizations for external reporting. The tool was unable to be implemented for this meeting; however, the delay will allow the IT implementation team to continue to add necessary integrations, and review and test tool functionality. Spencer Ferguson, the IT contractor who has been working to help build and integrate the functionality for the QRT interim automated solution, walked the QRT through updates since the last meeting, which includes integrating Power Apps to the tool on the front end for data validation to help reduce the likelihood of user error.	**Update:** Power Apps software has been integrated into the Master file for a front end data quality check.

		Highlights: Each SME will have their own custom link so they only see and have access to enter the PM's for which they are responsible. The tool will stay open for late changes until it is validated. Data entered is updated each night in Tableau. The tool lives on DBHDS SharePoint environment on the development site. The tool is not live at this time. When tool is ready to go live, we will grant the SME's access to enter data into the form (i.e. DMAS). SME's will receive an invite to log into a form which updates an underlying SharePoint list and captures what was entered on the form. SME's should bookmark the form for future access. When the form is opened users will see a list of all of the PM's that the user is responsible for entering. Across the top is the overall waiver assurance, the PFID and the waiver type. Users can filter by a specific assurance or use the search bar. Users can open the specific Performance Measure to enter data by clicking anywhere in the space above the letter or the arrow. The performance measure detail, SME e-mail address, and the start and end date for quarter will be prepopulated on the main screen. Users can hover and click on the pencil to enter the numerator denominator. There are additional free text columns for entering general notes about the PM, listing QMR CAPS each quarter and the CAP detailed information, remediation conducted each quarter, as well as information on CRC Training and TA delivered each quarter. At this time there is no character limit on the text fields. Users will check the checkbox in the top right of the screen to submit items. There will be a window of time in which SME's will be able to go back and correct/add information. Any added data will overwrite	

		previous data until the form is validated and submitted as complete for the quarter by the QRT Manager. At that time the form will be frozen until the next quarter's data entry. The IT team is in the process of transitioning this tool into a database environment to make the data as secure and sustainable as possible. Internal discussions within DBHDS have indicated that this process must now be both a short term and long term solution in Power Apps. It was shared that the goal is for the tool to be the only location where all QRT meeting data and supporting documentation is housed. This may mean that some information still coming in as supplemental documents and handouts, would need to be summarized for entry into the tool in the future. A committee member inquired whether a video tutorial or training could be developed before the go live date? It was noted that this can be accommodated if it would be helpful. The goa is for the tool to be able to be rolled out at the 4th quarter QRT meeting.	
5.0	**Overview QIC Meeting 6/28/2021**	The QRT is one of the committees reporting to the QIC. Several QRT PM's are reported to the QIC individually through the respective DBHDS department; however, all QRT PM's fall under the general oversight of the QIC. If a PM is below compliance for the QRT, this impacts CMS as well as DOJ reporting. The QIC meet on 6/28 and I delivered a summary of QRT performance for 2020. There were also three primary recommendations from 2020 EOY Report: I am due to report on progress toward implementing these recommendations at the September QIC meeting. Recommendations:	**Update:** Internal DBHDS meetings have occurred with QRT Lead to follow up on QRT recommendations. Reporting on QRT progress implementing the recommendations will occur during the September QIC meeting. :

		• Develop statewide, intra-agency processes to expand the reach to all DDW providers so that existing first line remediation is more effective. Because tracking performance is dependent on individual provider knowledge and performance, VA needs a way to ensure that it is reaching all providers, licensed and non-licensed, in the same way to ensure generalized knowledge, information, and access to DBHDS training resources. This translates to developing a location and a process for all providers to keep their contact information up to date. • Develop the capacity within the state for more innovative, on-demand training resources. The state has exceeded its capacity to be able to deliver targeted, in person trainings to providers with corrective actions (especially with the new mandatory remediation regulatory requirements). One solution is to develop existing and new training materials into online, on demand, targeted content. The content should be available in a tool/system that is able to track providers who access the content with a companion methodology developed that can determine if training interventions are effective in improving performance. • Invest in additional resources to modernize and streamline data reporting capability. The QRT has already y begun this process with development of the new QRT automated tool. The interim framework that has been developed has been determined to be the permanent solution to be able to meet the data reliability requirements of DOJ and capture source data for PM's in place of the requested resource (REDCap).	
6.0	**UPDATE: 2020 QRT EOY Report**	There is a requirement of the DOJ SA that the QRT prepare an annual report summarizing performance, that the results be shared	**Follow-up:** Continue follow up on all areas of deficiency.

		with CSB's for their feedback, and also posted to the web for stakeholder transparency. • 28 CSB's responded to the request for feedback on the QRT EOY Report through the survey monkey tool. Results have been posted to the 4th Quarter TEAMS folder. • <u>Missing 2020 data is still needed</u> before the EOY report can be posted to the DBHDS website, as per the DOJ SA provision, and recommendation from the SA Advisor. <u>Missing Data</u> • Human Rights/Office of Community Quality Management PM G7 (HSAG 2020 PCR Alerts ALL quarters) • Human Rights PM G1 (3rd and 4th Qtr. 2020)	
7.0	**G1 &G7: Updates:**	<u>G1 Human Rights Retrospective Reviews</u> *N = Number of closed cases of abuse/neglect/exploitation verified that the investigation was conducted in accordance with regulations* *D = Number of closed cases of abuse/neglect/exploitation that were reviewed* A timetable for acquiring data from delayed Human Rights retrospective reviews was requested to finalize the EOY report and include the 2020 data for PM G1 in the CMS Evidentiary report. Data is now available and will be sent. <u>G7 - QSR PCR Contractor Alerts</u> *N: Count of how many PCR alerts were issued to OHR that were NOT due to unauthorized restrictive interventions*	**Update:** **G1 Update:** Following meeting discussion, it was determined that this information is now available and will be provided for inclusion in the EOY and Evidence Report. **G7 Update:** The DBHDS QRT Lead and Office of Community Quality Management staff met 8/6 to discuss the specific infractions that should be counted as an unauthorized restrictive intervention that can be deducted from the denominator.

		D: total # of PCR reviews. In FY 2020, DBHDS entered into a contract with a new QSR contractor (HSAG) replacing the previous QSR contractor. As a result, DBHDS had not viewed QSR PM data for QRT reporting since the end of FY 2019. It has taken some time with the transition to the new contractor and several new DBHDS staff across department, to understand the requirements for the PM and review QSR information to determine what should be included in the PM data. As of Q3, the QRT awaited 2020 QSR data for inclusion in the EOY 2020 report and the CMS Evidentiary report, as well as 2021 data for 1st through 3rd Qtrs. QRT reporting. A meeting with the QSR Coordinator and the DBHDS Director of Human Rights, resulted in development of a plan moving forward regarding which alerts should be included in the count of those PCRS issued that are NOT due to unauthorized restrictive interventions. The process will include a review of all of the PCR's sent to Human Rights from HSAG, (incorporating of the denominator), and the Human Rights team will make the decision as to whether or the PCR was due to an unauthorized restrictive intervention or not (determination of numerator).	
8.0	**CMS Evidentiary Reporting**	It was reported that the CMS Evidentiary Report, an aggregation of three years' worth of data summarizing performance under the waiver assurances, is due to on DMAS 9/21 for submission to CMS on 9/28. The last QRT meeting noted a few issues which needed to be resolved prior to submission of the report. Discussion areas/updates: • There are inconsistencies between PM language in the CL and FIS waiver applications for QA reporting which actually	**Follow-up:** Meeting with DMAS was held 8/23 to determine to confirm path forward for Evidentiary Report.

		change how the information is viewed according to the PM. It does not appear that the language in the FIS waiver application was updated with the most recent CL amendments. Since the state is submitting one report (for all three waivers data) with the consolidated reporting, one option would be to add the correct wording to the template (templates are pre-populated with the PM language). The DMAS Policy Analyst will follow up at DMAS to ensure that this is allowable. • The second issue is acceptable documentation of individual Remediation Reporting to CMS for PM G4 (explained below).	
9.0	**G4: CMS Individual Remediation Reporting**: s	For PM G4, 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. Although the ANE form is a Human Rights form the citations from Licensing for HR are different than that of QMR. For the providers cited, DMAS recommends delivery of technical assistance versus a formal CAP. **QRT Discussion**: For the first time, this PM is below compliance for FY2020. Since it is a measure related to Appendix G: Recipient Health and Welfare, the state will need to demonstrate individual remediation for the PM. In past years, this has typically meant documenting successful completion of corrective actions plans during the review time period. The DMAS Supervisor prepared a compilation of TA remediation delivered during 2020 as recommended reporting of individual remediation delivered. Since provider names are not typically included in in the Evidence Report, an adjustment could be made to remove that level of detail and include only the TA numbers.	**Follow-up:** Schedule follow up meeting with DMAS.

After brief discussion, it was determined that this would be incorporated into a meeting with DMAS Leadership and the DMAS Sr. Policy Analyst in preparation for the Evidence Report submission. The compilation of recommended TA for 2020 is shown below:

<u>2020 Remediation:</u>

Q1 2020

Waiver	ProvName
CL	FAIRFAX-FALLS CHURCH CSB
CL	CHESAPEAKE INTERGRATED BEHAV HEALTHCARE

Waiver	ProvName
FIS	FAIRFAX-FALLS CHURCH CSB

Q2 2020

Waiver	ProvName
BI	IN HIS HANDS LLC

Waiver	ProvName
CL	APEX DAY SUPPORT SERVICES, LLC.
CL	BLUE RIDGE BEHAVIORAL HEALTHCARE
CL	DISTRICT 19 MEN HLTH SER
CL	IN HIS HANDS LLC
CL	CHESTERFIELD CSB
CL	SAFE HAVEN FAMILY SERVICES INC

Waiver	ProvName
FIS	APEX DAY SUPPORT SERVICES, LLC.

FIS	DISTRICT 19 MEN HLTH SER
FIS	IN HIS HANDS LLC

Q3 2020

Waiver	ProvName
BI	M T SORRELL INC

Waiver	ProvName
CL	DICKENSON COUNTY BEHAVIORAL HEALTH SVCS
CL	CITY OF VA BEACH CSB MHMRSAS
CL	M T SORRELL INC

Waiver	ProvName
FIS	CITY OF VA BEACH CSB MHMRSAS
FIS	VIRGINIA INSTITUTE OF AUTISM

Q4 2020

Waiver	ProvName
CL	CITADEL FAMILY SERVICES, LLC
CL	DIVERSITY IN-HOME SUPPORTS, LLC
CL	HANOVER COUNTY COMMUNITY SERVICES
CL	RAPPAHANNOCK RAPIDAN CSB

Waiver	ProvName
FIS	HANOVER COUNTY COMMUNITY SERVICES

10.0	**New DBHDS Risk Awareness Tool (RAT) Feedback**	During the most recent DMAS/DBHDS QMR/CRC meeting, QMR Reviewers reported frequent instances of incomplete documentation during reviews including the new DBHDS Risk Awareness Tool (RAT). Although the problem is not yet identified through the QRT the meeting is a place for Provider Development, QMR and OCQM to work together to develop resources for proper documentation of the information found in the tool, since it was/is one of the remediation tools identified to help improve provider performance in identifying and remediating risks QMR Reviewers spent a few months working with the tool and noticed instances of providers only uploading summary information from the RAT. In some cases, the uploaded summary did not capture key information from the plan, was completed partially with some questions skipped and/or left blank, and in one situation, a blank summary page was uploaded rather than the entire summary. The concern is that there might be risks identified in the top part of the RAT form; however, the last part of the form where risk mitigation would be demonstrated, is left blank. In at example used from the Therapeutic Consultation service, the tool did not accurately capture information from either the SIS, ISP or BSP, the evaluator's signature was missing, and the form was not typed or date stamped. Also, for some providers receiving Tier 4 Level 5-7 reimbursement, the documentation reviewed did not support the Behavior Support plan. There was considerable discussion during the meeting. Some discussion centered on the fact that the review is only done annually and that may be the reason why so much of this information is not being captured.	**Follow-up:** OIH will follow-up with DMAS QMR Supervisor. RAT reviews will be incorporated into QRT reviews on a periodic schedule to be determined by the team.

		The OIH Director explained that the RAT is not a risk assessment tool, but is used to identify the potential for risk of a fatal/adverse event. The goal is to encourage providers to seek a qualified health professional (QHP) to assess whether the individual is at risk for one of 7 health events. If the individual received a new diagnosis of one of the 7 health events during the past year, support instructions from the QHP should be included in the ISP. Providers would not need to complete the second section of the tool because the support instructions from the QHP in the ISP should be referenced to reduce the risk of a second related event. The support team and the individual have the option to decline QHP intervention (if they are already working with professionals, etc.) on these conditions; however it is designed to force ISP teams to have a conversation about the 7 health areas and the additional community risk areas at the time of the annual meeting. Providers were directed to only update the summary pages with the personal information section of the ISP. The sections filled out would be those asking if a personal risk was identified. The goal is have this eventually built into WaMS. It was noted that some providers just upload the whole form, since it is easier but this is not required. Discussion from the QRT included a request that providers be asked to upload more than one page to allow all reviewers to be able to follow the conversation that occurred with regard to health conditions that are being monitored for risk mitigation. It was clarified that the former risk assessment tool is still required to be completed annually with the SIS and is no longer a standalone document. It was also noted that this additional documentation request is only triggered for those with exceptional needs.	

		The OIH conducted a sample review of the Risk Awareness tool over two quarters with feedback specific to each CSB. This feedback is being finalized and written up as a formal process. There is a report that can be used to incorporate the information and summarize of what was seen during the review. With review of the process, OIH is sharing feedback on incomplete documentation with providers. All of the concerns from QMR will be added to the cover letter sent to the CSB's. Documentation about these reviews can be made available as part of QRT reporting moving forward. The OIH Director will follow up with the DMAS QMR Supervisor (not present at the meeting) and her team to make sure that they are informed about the full purpose of the process. The RAT tool, FAQ document, and recorded slides are available for review at COVCLC; however, OIH will conduct technical assistance and/or training for any remediation that needs to occur for providers with a QMR CAP.	
II.	***Review and Discussion of 3rd Qtr. (1/1/2021-3/31/2021) QRT Data* (PM's with percentages reported below the 86% threshold for 3rd Quarter meeting).**		
C8	**Number and percent of provider agency staff meeting provider orientation training requirements.** **3rd Qtr. compliance CL 71/102 (69%), FIS 6/9 (66%), BI 4/9 (44.4%)** **<u>CAPS</u>** **3rd Quarter-** **BI 1 CAP** • Highlands CSB – Orientation test not scored **CL – 5 CAPs** • Allay – Had not been completed		**Follow-up:** Confirm with Provider Development that the orientation requirement is incorporated into the competencies QII.

	• Highlands – Not scored • Eagles Nest – None of the personnel in sample had an Orientation test in record • Alleghany – Test not scored • Piedmont – Not completed, not scored **FIS: 2 CAPs** • Allay – Had not been completed • Giving Hearts – Had not been completed • **Remediation:** This PM (provider orientation) had improved for 2020 (Aggregate total for all waivers for FY2020 was 86% which is just within the required threshold, which was T an increase from FY2019 (83.96%). However numbers for 2021 are trending back in the wrong direction. It was noted that a QII continues to be implemented for the provider orientation and competencies. The PM will continue to be reviewed for improvement throughout at least the next quarter for demonstrable improvement. This will also be addressed during the new mandatory provider remediation process, once fully implemented. This PM should continue to be added as a reminder in notices to providers and included as an agenda item for the PRT.	
C9	**Number and percent of provider agency direct support professionals (DSPs) meeting competency training requirements.** **3rd Qtr. compliance CL 61/78 (78.2%)** **CAPS** **3rd Quarter – –** **CL 5 CAPS** • Alleghany CSB: Not completed with 180 days, Checklist missing • Eagles Nest: No checklist, not completed annually	**Follow-up:** Continue developing process and protocols for mandatory provider remediation that will include this PM. Reminders should continue to be shared during the PRT and QII training will continue.

	• Giving Hearts: No checklist • Highlands: No checklist, no advanced competency checklist • Piedmont: proficiency confirmed not indicated, not signed, checklist not in record **Remediation:** The aggregate total for this PM for all waivers during FY2020 was 63% which is increased slightly from FY2019 (55.89%) but still well below the required threshold. QII being implemented for provider orientation and competencies. This PM should continue to be added as a reminder in notices to providers and included as an agenda item for the PRT and will also be addressed during the new mandatory provider remediation process, once fully implemented. The QRT will continue to observe this PM through the next quarter until the end of the 2021 for demonstrable improvement. It was noted that compliance percentage has steadily increased but still shows noncompliance. If the percentages are still below compliance at the conclusion of FY2021 reporting, we will readdress it with tweaks to the QII. A suggested vehicle for intervention would be recorded, on demand training videos. The QRT will follow up with regard to developing the capacity for developing video training content with an assessment component within the Department. OIH has plans to develop voice over recordings for the advanced competency trainings.	
D1	**Number and percent of individuals who have Plans for Support that address their assessed needs, capabilities and desired outcomes.** **3rd Qtr. Compliance: CL 165/197 (83.8%), FIS 48/63 (76.2 %),** **CAPS** **3rd Quarter** **FIS 5 CAPs**	**Follow-up:** Continue to add to the PRT agenda and provider list serve as reminders. Re-examine the measure at the end of the quarter.

	• Brandywine: SIB • Exceptional People: Emotional outbursts not specifically addressed • Piedmont CSB: all risk due to blindness & issues with depth perception- • Visionary Family Services: Prevention of sexual aggression not addressed • Ward Transitional: I.E. Emotional outbursts, fall risk, choking, transferring, safety skills in kitchen, property destruction **CL 8 CAPs** • Alleghany CSB: Emotional Outbursts, inappropriate sexual behavior • Brandywine: SIB • Eagles Nest: Obstructive sleep apnea; prevention of stealing • Wards Transitional: i.e. wandering, falls risk, seizures, prevention of theft, allergies • Visionary Family Services: Prevention of sexual aggression not addressed • Piedmont CSB: Dialysis port, shunt, emotional outburst, wandering, falls, • Highlands CSB: SIB, bowel-obstruction • Mt Rogers: Seizure management, wound care, property destruction, wandering, emotional outbursts, prevention of assault & injury and prevention of stealing This PM was also below compliance for 2020. The aggregate total for FY2020 is 80% which is decreased from FY2019 (87%). **Remediation:** A downward trend for the PM continued through 2020 as it has for the past several years, with 2021 numbers shown below compliance as well. The measure will likely require systemic remediation in the CMS Evidence Report. The QRT plans to present the new RA tools as part of the state's systemic remediation solution for these and other related PM's. Continued observation of this and related measures will help determine if the new risk awareness/mitigation tools are working to prevent incidents and fatal events and improve compliance with the PM. This PM should continue to be added as a reminder in notices to providers and included as an agenda item for the PRT.	

D3	**Number and percent of individuals whose Plan for Supports includes a risk mitigation strategy when the risk assessment indicates a need.** **3rd Qtr. Compliance: CL 51/65 (78.5%) FIS 12/26 (48%)** **CAPS** **3rd Quarter –** **FIS 4 CAPS** • Brandywine**:** SIB • Exceptional People: Emotional outbursts not specifically addressed • Piedmont: fall risk • Visionary Family Services: Prevention of sexual aggression not addressed **CL 4 CAPs** • Brandywine: SIB • Eagles Nest: Obstructive sleep apnea; prevention of stealing • Wards Transitional: I.e. wandering, falls risk, seizures, prevention of theft, allergies • Visionary Family Services: Prevention of sexual aggression not addressed **Remediation:** This PM was also below compliance for 2020. The aggregate total for FY2020 was 72%. Systemic remediation is likely required (see discussion for PM D1 above.)	**Follow-up:** Continue to add to the PRT agenda and provider list serve as reminders.

	This PM should continue to be added as a reminder in notices to providers and included as an agenda item for the PRT.	
D6	**Number and percent of individuals whose service plan was revised, as needed, to address changing needs.** **3rd Qtr. Compliance: FIS (50%)** **3rd Quarter** – **FIS 1 CAP** • Ward Transitional: Fall in August 2020 bruised rib. Went to urgent care; Individual completed an endoscopy to see why he was vomiting daily. On 10/5/20. No documentation of result of endoscopy or significant issues after or if additional supports were needed. **Remediation:** Performance for 2020 was just at the required threshold of 86%. This PM has a long standing history of lower performance. The mandatory provider remediation should help, but the QRT may want to recommend other remediation activities to try to prevent compliance from decreasing further. It was also suggested that the QRT follow up with the QMR Supervisor to inquire which service is reflected in the 3rd Qtr. FIS numbers (50%), to determine what might have occurred differently with that waiver. This PM should continue to be added as a reminder in notices to providers and included as an agenda item for the PRT	**Follow-up:** Continue to add to the PRT agenda and provider list serve as reminders. Follow up with the QMR Supervisor re: the service is reflected in the 3rd Qtr. FIS numbers (50%).
G4.	**Number and percent of individuals who receive annual notification of rights and information to report ANE.** **For 3rd Qtr. Compliance CL 85/108 (78.5%) BI 5/9 (55.6%)**	**Follow-up:** This PM should be added as a reminder in notices to providers and included as an agenda item for the PRT.

	3rd Quarter – **CL 5 TAs:** • Eagles nest: NO documentation provided, • Exceptional People Plus: not done annually • Giving Hearts: No documentation ANE reviewed annually • Highlands CSB: not updated annually, • Mt Rogers CSB: signatures missing, not updated annually **FIS 3 CAPS** • Exceptional People Plus: not done annually • Giving Hearts: Not in record • Highlands CBS: Not done annually BI 3 CAPS • Giving Hearts: Not in record • Highlands CSB: Not done annually • Mt Rogers CSB: Not signed Also see G4 discussion in Section I of the agenda. The aggregate total for 2020 is (85%). This is the first time that this PM has shown low performance. Individual remediation conducted will need to be included in the evidence report. **Remediation:** This PM should be added as a reminder in notices to providers and included as an agenda item for the PRT.	
G5	**Number and percent of critical incidents reported to the Office of Licensing within the required timeframes as specified in the approved waiver.** Licensing data was reviewed via message sent through TEAMS (8/18)	**Follow-up:** Data received indicates that the PM data was in the range of compliance.

	2309/2452= (94%)	
G6	**Number and percent of licensed DD providers that administer medication that were not cited for failure to review medication errors at least quarterly** Licensing data was reviewed via message sent through TEAMS (8/18) 274/296=(93%) The percentage compliant is a marked improvement from last quarter (79%).	**Follow-up:** Data received indicates that the PM data was in the range of compliance.
	New agenda items added **None**	