FY 2021 4th Qtr. QRT Meeting Summary
1/12/2022 (4th QTR)
for 1st Quarter Meeting 3/30/2021

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	
I.	**Follow-up/ and global updates**		**Follow-up**

1.0	**Waiver Operations QRT TEAMS folder**	**UPDATE:** The use of BOX for QRT document sharing has been discontinued. QRT files will be moving to a new private Waiver Operations TEAM folder individual channel. There will be more information once the conversion is complete and permissions are set for QRT members.	**Follow-up: N/A**
2.0	**QRT App 2020 Tableau Integrations**	• The primary developer for the QRT App provided a demo to the QRT with basic visualizations captured from SFY 2020 data. • Highlights: the average percent of PM's met in SFY 2020 is 79% with 21% not met. During SFY 2020, measures not met peaked in the second and third quarter and then decreased in 4th quarter. • The Go Live date for the tool is projected for the 2nd Qtr 2022 QRT meeting (anticipated May 2022). • A formal request for additional resources dedicated to QRT App support and maintenance (following deployment) have been added to the internal DBHDS ITIB meeting agenda for discussion and approval.	**Follow-up:** Targeted communication to data SME's about upcoming app testing and deployment.
3.0	**Settlement Agreement Reporting**	**UPDATE:** In the DOJ SA consultant's most recent report, concern was raised with regard to the length of time that it takes to produce the QRT EOY report and make the information available for public dissemination. As such, DBHDS Leadership has requested that the report be completed and published on the DBHDS website within six months of the end of the SFY. While recognizing that there are multiple internal/external systemic barriers to timely reporting of the data for public consumption, the QRT will work to meet this goal. The QRT	•

		team was reminded that the next four months should be spent being planful in preparing for how the data will be reported using the new QRT tool. This would include communicating deadlines with external vendors, subcontractors and others from whom data used for QRT is solicited, and may also require delegating submission of QRT data to ensure that it is received within the required timeline. A reasonable timeframe will be implemented for entering data into the tool and this timeframe and the process will be communicated to all QRT Data SME's in advance. To assist with compliance/quality monitoring, the QRT has also been granted the authority to recommend development and implementation of formal or informal quality improvement initiatives (QII) in response to demonstrated low compliance of a PM. The QII approval process includes accountability through designation of DBHDS resources to implement the QII. Since the QRT does not own any of the data reported, QII's will be developed and implemented by the data owner's department/agency, with possible input from the QRT to ensure that the QII meets the goals/objectives of the PM. Any QII developed in response to a QRT recommendation must include ongoing monitoring and tracking with progress reported back to the QRT.	
4.0	**Consolidated Evidence Report**	**Updates:** • The final Evidence Report was submitted to CMS prior to the holidays. A response has not been received. • The next opportunity to update the QRT PM's will be during the next waiver renewal in 2023. Prior to this, a subgroup will be formed between DMAS and DBHDS QRT SME's to recommend revisions to PM's and review data in advance of submitted PM changes to CMS. • The QRT was reminded that even if PMI's are updated/revised, ALL SME's must continue to report	**Follow-up:** Schedule meeting with QRT subgroup in late Spring (3rd Qtr 2022) to begin the process of proposing and reviewing changes/new PM's for waiver renewal period (2023).

		QRT PM data as usual until the waiver renewal is submitted and approved with new PM's. • The QRT was notified that the following incorrect denominators in the following PM are included in the waiver application. This will be updated with the waiver renewal. I believe this is C10 in QRT chart **Performance Measure C3:** — 3. Number and percent of enrolled licensed/certified provider agencies continuing to meet applicable licensure/certification following initial enrollment. Numerator: **Number of enrolled licensed/certified providers, continuing to meet applicable licensure/certification** Denominator: **Total # of enrolled licensed/certified provider agencies** Description of Data Source: Provider Enrollment Reports I Believe this is C3 on QRT report **Performance Measure C3:** — 3. Number and percent of enrolled licensed/certified provider agencies continuing to meet applicable licensure/certification following initial enrollment. Numerator: **Number of enrolled licensed/certified providers, continuing to meet applicable licensure/certification** Denominator: **Total # of enrolled licensed/certified provider agencies** Description of Data Source: Provider Enrollment Reports *For both PM's QMR Reviewers should be the data source.*	
6.0	**Risk Awareness Tools: Continued Discussion**	**UPDATE:** As a follow up to the last meeting discussion, the OIH Director and QMR Supervisor met to determine consistency in citing irregularities in the use of the RAT. During the meeting, QRT discussion included types of data to bring back to the QRT for review as surveillance data. The OIH	**Follow-up:** • FAQ's on OSVT, RAT and the Crisis Risk Assessment Tools • Training on the OSVT (The RAT Training is being updated on the COVLC website)

		has conducted different types of reviews and is also thinking about which reviews should be done consistently for future standardized reporting. To determine the utility of this data, it was noted that some of this data can be filtered through other smaller workgroups such as the QMR/CRC Quarterly meeting. Information potentially reported to the QRT could include: • Data from QII Falls with Injury Workgroup • Sample review data from execution of the RAT The OIH Director will also share with her team information from QMR reviews – bulleted list of observational feedback? This can be shared with the QRT members for perspectives on next steps? The OIH Director will bring feedback on this to the next meeting.	• Memo regarding the relocation of the Case Management Employment Training module to the COVLC from the Partnership website.
7.0	**.**	**<u>G1 Human Rights Retrospective Reviews</u>** **Update:** **PM G1** - OHR data from the Community Look-Behind process that was delayed due to the pandemic was provided to the QRT.	**Follow-up:** See G1 discussion below.
II.	***Review and Discussion of 4th Qtr. (4/1/2021-6/30/2021) QRT Data* (PM's with percentages reported below the 86% threshold for the Quarter).**		
C2	**Number & percent of licensed/certified waiver provider agency staff who have criminal background checks as specified in policy/regulation with satisfactory results.** **4th Qtr Compliance CL 124/146 (84.9%), FIS 24/31 (77.4%), BI 3/5 (60%)**		**Follow-up:** None Since the PM is in compliance for the year, we will continue to observe performance for the next two quarters of 2022.

	PM Average All Waivers **EOY 2020/2021= Compliant** **482 / 538 = 90%** **4th Quarter** **BI 1 CAP** • Quality Life Services - NO DOC TO PROVE CRIM CHECK CONDUCTED **FIS 2 CAPS** • NYA – No CRC provided • Progressive – CRC requested several months after hire **CL 6 CAPS** • Capriccio - According to provider, 2017 results were lost when transferring to electronic storage. DBHDS will not release results after a year. • Henrico CSB – no documentation of being done, completed late • NYA – No CRC provided • Progressive – Results could not be located, completed late, • Pieces of Dreams – CRC Completed late • Quality Life - NO DOCUMENTATION TO PROVE CRIM CHECK COMPLETED. Completed several months after hire - Ongoing issues reported to be related to the providers sampled each quarter.	
C5	**Number & percent of non-licensed/noncertified provider agency DSPs who have criminal background checks as specified in policy/regulation with satisfactory results.** **4th Qtr Compliance CL 2/5 (40%), FIS 1/3 (33.3%)** **PM Average All Waivers** **EOY 2020/2021 = Compliant**	**Follow-up:** Therapeutic consultation providers – these may be newer providers.

	<table><tr><td>71 81</td><td>88%</td></tr></table> **4th Quarter** **CL 3 CAPS** • CREATIVE APPROACH DEVELOPMENT CENTER LLC – No doc of CRC • EXCEL GROWTH THERAPIES LLC – CRC completed late, CRC not done • QUEENS UNITED WELLNESS CENTER – CRC completed late **FIS 2 CAPS** • CREATIVE APPROACH DEVELOPMENT CENTER LLC no doc of CRC • EXCEL GROWTH THERAPIES LLC – requested late, results not presented During discussion, it was noted that the QMR CAPS represented the Therapeutic Consultation service accessed through Service Facilitation. The providers cited (Queens United) were newer providers. SF providers receive the Medicaid Memos from DMAS but may not be receiving provider e-mails from the provider listserv which provide reminders of requirement under the waiver regulations.	
C8	**Number and percent of provider agency staff meeting provider orientation training requirements.** **4th Qtr. compliance CL 107/139 (80%), BI 3/4 (75%)** **PM Average All Waivers** **EOY 2020/2021 = Noncompliant** <table><tr><td>423 542</td><td>78%</td></tr></table> **4th Quarter**	**Follow-up:** This PM should continue to be added as a reminder in notices to providers and included as an agenda item for the PRT. The QRT Manager will follow up with Provider Development regarding the new proposed QII to address improvements in provider orientation and competencies and will follow up with QMR to determine if a RCA can be added to the CAP completion progress.

	CL 5 CAP • DANVILLE-PITTSYLVANIA COM SERV not date, not scored • HENRICO AREA MENTAL HLTH & DEVLPMNTL SVC – no documentation of orientation test provided • NYA HEALTH SERVICES INC – Not scored, not provided • PIECES OF DREAMS, LLC – Orientation test not scored or dated • QUALITY LIFE SERVICES – Not scored, not present **BI 1 CAP** • Quality Life Services – no score, not present 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. This is an increase from FY2019 (83.96%) but noncompliance #'s are going back up. (A statewide QII for this PM is being implemented for provider orientation and competencies. The PM C8 and C9 were discussed together. **Update:** Independent of a formal recommendation from the QRT, the QIC has approved a new QII for this measure that is reliant on using QSR data in place of DMAS data. This QII includes HSAG interviews with individuals to determine their satisfaction with services in a number of areas that also cover HCBS requirements. Thought this QII does not use the CMS-approved data source for waiver assurance PM reporting, the QRT should monitor this as a surveillance data source and a possible new data source for the waiver renewal. The QRT will obtain more specifics on the new QII for the next meeting. THE QRT also discussed specific CAPS issued for the PM. Inquiries included whether these provider have been cited for the same thing before, and how the QMR assures that cited providers remain in compliance? It was noted that there is a follow up to the issued CAP that indicates whether the provider is in compliance or not. If not, the provider will receive another visit. Providers are now able to submit attestations for	

	some follow-up due to a temporary cessation of onsite visits due to COVID. Ordinarily, this is tracked in person and QMR reviewers are able to confirm that the plans were implemented. The QRT discussed the utility of requiring providers to conduct a root cause analysis in conjunction with completion of the CAP. It was noted that there could be process issues not limited to that provider that can be identified and shared in provider training. Also discussed was whether issuance of a CAP requires completion of a Root Cause Analysis (RCA). Although there are a number of reasons why a provider may have been cited as noncompliant, a RCA can identify the problem and help track it backward to the cause. DMAS will look at how this can be included in the process. 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 will also occur with DMAS QMR to determine if a RCA or similar process can be incorporated into a CAP as an informal QII for the PM. This will be a topic moving forward with regard to changes that could be made to the performance measures and remediation activities for discussion in preparation for the 2023 waiver renewal.	
C9	**Number and percent of provider agency direct support professionals (DSPs) meeting competency training requirements.** **4th Qtr. compliance CL 49/86 (57%), FIS 12/19 (63%), BI 1/2 (50%)** **PM Average All Waivers** **EOY 2020/2021 = Noncompliant** **235 / 393 — 60 %**	**Follow-up:** This PM should continue to be added as a reminder in notices to providers and included as an agenda item for the PRT.

	<u>CAPS</u> **4th Quarter** **BI 1 CAP** • Progressive – no documentation of 241a **CL 3 CAPS** • NYA HEALTH SERVICES INC – proficient confirmed not checked • PROGRESSIVE SERVICES OF VIRGINIA LLC – 241a not present • QUALITY LIFE SERVICES – only signature pages provided **FIS 3 CAPS** • HENRICO AREA MENTAL HLTH & DEVLPMNTL SVC – unable to determine if completed within 180days • NYA HEALTH SERVICES INC proficiency confirmed not checked • PROGRESSIVE SERVICES OF VIRGINIA LLC – 241 not present **Remediation:** The aggregate total for this PM all waivers for 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. According to continuous quality monitoring, this PM should be reviewed for modification to the QII. **See discussion in C9.**	
D1	**Number and percent of individuals who have Plans for Support that address their assessed needs, capabilities and desired outcomes.** **4th Qtr. Compliance: CL 217/265 (81.9%), FIS 70/84 (83.3 %), BI 13/17 (76.5%)** **PM Average All Waivers** **EOY 2020/2021 = Noncompliant** **920**	**Follow-up:** Add to the PRT agenda and provider list serv as reminders. The QRT will follow up with discussion with regard to potential data that can be shared with regard to the aforementioned QII's.

1098	84%

4th Quarter
CL 8 CAPS

- DANVILLE-PITTSYLVANIA COM SERV – behaviors, falls, ASPIRATION PNEUMONIA & SEPSIS, AS IDENTIFIED ON RAT, bp, suprapubic bag
- HENRICO AREA MENTAL HLTH & DEVLPMNTL SVC - , elopement, choking, volunteer activities,
- NORFOLK COMMUNITY SERVICES BOARD – choking, prevention of self harm, behaviors, suicide attempts, prevention of stealing
- NORTHWESTERN COMMUNITY SVCS – falls, behavior/ lack of safety awareness
- NYA HEALTH SERVICES INC – sepsis, dehydration, elopement, seizures
- PIECES OF DREAMS, LLC – HTN, nebulizer
- PROGRESSIVE SERVICES OF VIRGINIA LLC – seizure disorder, prevention of pressure sores
- QUALITY LIFE SERVICES – diabetic diet and monitoring, prevention of falls, seizures

FIS 7 CAPS

- CAPRICCIO ELITE, LLC – blood sugar monitoring, blood pressure
- FAMILY SENIOR PARTNERSHIP LLC – assault and injury to others, sib
- HENRICO AREA MENTAL HLTH & DEVLPMNTL SVC - falls
- NORFOLK COMMUNITY SERVICES BOARD - falls
- NORTHWESTERN COMMUNITY SVCS – chronic constipation, falls
- NYA HEALTH SERVICES INC – prevention of self injury, elopement
- PROGRESSIVE SERVICES OF VIRGINIA LLC – elopement, sib

BI 3 CAPS

- DANVILLE-PITTSYLVANIA COM SERV – monitoring stunt blockage, seizures

	• HENRICO AREA MENTAL HLTH & DEVLPMNTL SVC – seizure disorder, diabetes • NORFOLK COMMUNITY SERVICES BOARD – elopement, wandering **Remediation:** This PM was also below compliance for 2020. The aggregate total for FY2020 is 80% which is decreased from FY2019 (87%). A downward trend for the PM continued for 2020 as it has for the past several years. During QRT discussion, it was noted that due to low compliance, the measure will require systemic remediation for 2022. Further, since the existing QII has not had resulted in consistently upward trending compliance, a formal or informal QII may be needed. Compliance for this PM has been increasingly challenging. During QMR reviews, it is reported that the Plans for Support often do not address all of the needs the individual has for health and safety, and also do not address things that the person wants to do, the goals they want to achieve, etc. QRT discussion included a summary of ongoing interventions within DHDS to encourage improvement. There is a Care Concerns process within the Office of Licensing where fall information is aggregated to determine which are appropriately categorized as a health and safety care concern. The information is forwarded to Human Rights and the OIH and is followed up with the provision of education, tools and resources, as well as in-person follow up. Some have specific training targeted to the individual provider. There has also been considerable effort to get providers to document changes in status when they occur. The OIH Director will look to see if any of these providers are also showing up on HSAG QSR reviews or the IMU Care Concerns process to determine if there is any crossover and if those units have ideas about how to bring providers into compliance. These units are walking boots on the ground and have direct contact with providers and may spur some ideas outside of the QRT. The Care Concern process is not intended to address a specific event that occurs but to identify a pattern in care concerns and the core issues that need to be addressed so that	

	the state can support them by leveraging the ongoing learning and a fresh perspective to see if there is something that can be done differently. During discussion, it was shared that a DBHDS staff person from RQC 2 has a QII that the QRT might follow with regard to falls with injuries. The QII includes a collaboration with JMU Kinesiology. It is hoped that information from this project could be leveraged across all of the regions. This PM should continue to be added as a reminder in notices to providers and included as an agenda item for the PRT. The QRT will follow up with discussion with regard to potential data that can be shared with regard to the aforementioned QII's. This will be a topic moving forward with regard to changes that could be made to the performance measures and remediation activities for discussion in preparation for the 2023vwaiver renewal.	
D3	**Number and percent of individuals whose Plan for Supports includes a risk mitigation strategy when the risk assessment indicates a need.** **4th Qtr. Compliance: CL 153/193 (79.3%) FIS 41/57 (71.9%) BI 2/5 (40%)** **PM Average All Waivers** **EOY 2020/2021 = Noncompliant** **358 / 467 = 77 %** **4th Quarter** **CL 8 CAPS** • DANVILLE-PITTSYLVANIA COM SERV – behaviors, falls, ASPIRATION PNEUMONIA & SEPSIS, AS IDENTIFIED ON RAT, bp, suprapubic bag • HENRICO AREA MENTAL HLTH & DEVLPMNTL SVC - , elopement, choking, volunteer activities,	**Follow-up:** Add to the PRT agenda and provider list serv as reminders. The QRT will follow up with discussion with regard to potential data that can be shared with regard to the RMRC incident template.

	• NORFOLK COMMUNITY SERVICES BOARD – choking, prevention of self-harm, behaviors, suicide attempts, prevention of stealing • NORTHWESTERN COMMUNITY SVCS – falls, behavior/ lack of safety awareness • NYA HEALTH SERVICES INC – sepsis, dehydration, elopement, seizures • PIECES OF DREAMS, LLC – HTN, nebulizer • PROGRESSIVE SERVICES OF VIRGINIA LLC – seizure disorder, prevention of pressure sores • QUALITY LIFE SERVICES – diabetic diet and monitoring, prevention of falls, seizures **FIS 6 CAPS** • CAPRICCIO ELITE, LLC – falls due to seizures not specifically addressed • FAMILY SENIOR PARTNERSHIP LLC – SIB, prevention of assault • NORFOLK COMMUNITY SERVICES BOARD – dehydration, diabetes • NORTHWESTERN COMMUNITY SVCS, wandering, diabetes, elopement • NYA HEALTH SERVICES INC – emotional outburst, wandering, lack of safety awareness • PROGRESSIVE SERVICES OF VIRGINIA LLC **BI 2 CAPS** • DANVILLE-PITTSYLVANIA COM SERV – monitoring swelling of shunt • NORFOLK COMMUNITY SERVICES BOARD – elopement **Remediation:** This PM should continue to be added as a reminder in notices to providers and included as an agenda item for the PRT. **This PM was also below compliance for 2020. The aggregate total for FY2020 was 72%. A downward trend for the PM continued for 2020 as it has for the past several years.** The measure will require systemic remediation for 2021. In response to noncompliance with the above PM, the QRT was informed of the Risk Management Review Committee proposed template to track how incidents are reviewed (their frequency and the internal data reflected in reports pulled from the system. This information is intended to help inform their internal QI process and how we can translate specific situations to action.	

	This will be a topic moving forward with regard to changes that could be made to the performance measures and remediation activities for discussion in preparation for the 2023vwaiver renewal.	
D6	**Number and percent of individuals whose service plan was revised, as needed, to address changing needs.** **4th Qtr. Compliance: CL 21/40 (52.5%) BI 3/5 (60%)** **PM Average All Waivers** **EOY 2020/2021 = Noncompliant** **89 / 118 — 75 %** **4th Quarter** **BI 2 CAPS** • HENRICO AREA MENTAL HLTH & DEVLPMNTL SVC - Increase in ISE support hours due to increased and changed duties on task list at work, (Pandemic cleaning protocols) which resulted in increased training and support needs. • NORFOLK COMMUNITY SERVICES BOARD incident of being missing, plan not updated to include wandering **CL 6 CAPS** • DANVILLE-PITTSYLVANIA COM SERV - HOSPITALIZED WITH PNEUMONIA. THEN DIAGNOSED WITH STAGE 3 CANCER. D/C HOME WITH HOSPICE CARE & HAD NO CHANGE IN SUPPORTS NOTED. ON PLAN OF CARE • FAMILY SENIOR PARTNERSHIP LLC8 – use of walker • HENRICO AREA MENTAL HLTH & DEVLPMNTL SVC new diagnosis of dehydration, threat to commit suicide • NORTHWESTERN COMMUNITY SVCS – seizures, no update after fall	**Follow-up:** This PM should continue to be added as a reminder in notices to providers and included as an agenda item for the PRT**.** The QRT will continue to monitor performance through the next two quarters of FY 2022 with an update on the mandatory provider remediation process.

	• NYA HEALTH SERVICES INC – knee banging, brittle bones dx • QUALITY LIFE SERVICES, hosp for dehydration w/DX: pneumonia + sepsis + fall w/lacerations, elopement, not updated after stroke **Remediation:** PM performance for 2020 was just at the required threshold of 86%. Compliance has decreased from 2020. The PM has a long standing history of lower performance. The QRT briefly discussed the mandatory provider remediation as a remediation and was updated on the current status. During discussion it was noted that these providers should be included in the cohort needing mandatory remediation. As an update, the QMR Supervisor reported that providers needing mandatory remediation will include those that licensing has deemed need increased monitoring (since they see providers more than QMR). QMR is continuing to develop the protocol with the implementation date TBD. The protocol developed will also include information on review of policies and documentation for HCBS requirements. As a test, QMR has applied the protocol to sample providers to determine where that provider would fit into the table indicating the threshold for mandatory remediation. It is still TBD whether or not the interdisciplinary review will be incorporated into the process. D6, D3, D1 – additional projects to be included for discussion and action. This PM should continue to be added as a reminder in notices to providers and included as an agenda item for the PRT. A full update on the mandatory remediation process will be provided to the QRT at a future date. This will be a topic moving forward with regard to changes that could be made to the performance measures and remediation activities for discussion in preparation for the 2023vwaiver renewal.	

D8	**Number and percent of individuals who received services in the duration specified in the service plan** **4th Qtr. Compliance: FIS 33/42 (78.6%) BI 3/4 (75%)** **PM Average All Waivers** **EOY 2020/2021 = Compliant** **608 / 641 = 95%** **4th Quarter** **FIS 1 CAP** • FAMILY SENIOR PARTNERSHIP LLC – The provider was cited due to the fact that the individual plans covered 2 years. Although service authorization is for a two year period, the plans must be reviewed annually. It was theorized the state may not have communicated expectations for these providers well enough. However it was noted that the services not licensed by DBHD, still have a certain set of expectations with regard to performance that all providers have to comply with regardless of credentialing. The service cited was Service Facilitation which is not a DD waiver service/provider. Current and previous discussion has focused on the fact that Service Facilitation providers do not get the same training as DD CM's. Additionally, training is required every five years for SF's, which leaves a large knowledge gap. The QRT has considered having some areas of low compliance addressed in the trainings completed by SF's. The DMAS Policy Analyst will follow up to see if a training can be developed to encompass the most commonly seen areas of noncompliance in the CCC Plus and DD waivers and noncompliance that is seen within waiver types. Both DDS and DMAS can work together to develop the training. It was noted that the percentage compliant for	**Follow-up:** DMAS consideration of updates to SF training topics

	2021 is within compliance; however, noncompliance may be seen at a future point in time, due to the sampling methodology.	
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.** **PM Average All Waivers** **EOY 2020/2021 = Noncompliant** **256 / 300 = 85%** **Remediation:** Annual compliance is at 85%. It was noted that remediation is occurring which will improve the compliance numbers over time. Human Rights developed a specific ANE training for providers that more and more providers are taking. During CHRIS training, the way that the compliance measures and the investigations are tied into CHRIS are discussed, so compliance should improve from this perspective also. It was also noted that there are several new barriers to compliance with the PM. The community look behind process which has been operationalized in Human Rights, is used to demonstrate compliance for this PM and other departmental quality assurance. It was recently discovered that the way that the sample has been pulled does not assure that all of individuals in the sample are on the waiver. This is important to ensure data quality and reliability as mandated by DOJ. For this reason, the community look behinds are on pause and so there will not be data for PM G1 for 2022. There is no ETA and it is not known when there will be data. The pause in data collection will not	**Follow-up:** Internal conversations needed within DBHDS and DMAS to discuss cessation of the community look behinds

	change how Human Rights supports investigations; however, it does impact PM reporting for this measure. The QRT was requested to assist in elevating this issue. It will be important for all DBHDS QA entities to understand that data must continue to be collected as outlined in the CMS waiver application throughout the waiver reporting period, to maintain compliance with CMS waiver assurance requirements. Other ways of obtaining information on provider compliance with abuse and neglect data were discussed. The # of reports from a particular period and the # of providers cited for a particular investigation could be pulled; however, the numbers will still originate from a report where we cannot be 100% certain that the person is on a DD waiver. It was suggested that we could pull the waiver application from the CMS portal to see exactly how the data source from Human Rights is written in the application to determine if it specifically references the look-behinds. The issue will also be followed up internally with DHDS and DMAS leadership. This will be a topic moving forward with regard to changes that could be made to the performance measures and remediation activities for discussion in preparation for the 2023 waiver renewal.	
G4.	Number and percent of individuals who receive annual notification of rights and information to report ANE. **For 4th Qtr. Compliance CL 104/186 (55.9%) FIS 37/64 (57.8%) BI 12/17 (70.6%)** **PM Average All Waivers** **EOY 2020/2021 = Noncompliant** **499 / 706 = 71%** **4th Quarter** **CL 7 TAs**	**Follow-up:** Discussion/meeting needed between Human Rights, DBHDS Policy Compliance and DMAS QMR about reviewing what Human Rights considers an acceptable form of documentation of the annual review to integrate both standards.

	• DPCSB not present, not updated annually • Norfolk CSB –not completed annually • Pieces of Dreams – not completed annually • Progressive Services – not in record • Quality Life Services – not signed, not completed annually • NYA Health Services – not in record, not completed annually • Henrico CSB – no signature or verbal consent, not completed annually **FIS 6 TAs** • Henrico CSB – no signature or verbal consent, not completed annually • Capriccio Elite – not completed annually • Northwestern CSB – not updated annually • Norfolk CSb – not updated annually • NYA Health Services - not in record, not completed annually • Progressive Services – not in record **BI 3 TAs** • Progressive Services – not in record • Henrico CSB – no signature or verbal consent, not completed annually • Quality Life Services – not completed annually **Remediation:** The aggregate total for 2020 is (85%) now decreased to 71%. This PM should be added as a reminder in notices to providers and included as an agenda item for the PRT. <u>Additional remediation needed</u>. The QRT also discussed utilizing a similar standard between the information that QMR would require of providers to document ANE rights were communicated, and what Human Rights would accept as compliance. For QMR remediation, no citation is given; however, technical assistance is delivered. This TA is documented but there is no follow-up as there would be with an official CAP. This would be another way to demonstrate compliance that would involve Human Rights intervention as remediation and a CAP for noncompliance. For example, Human Rights only requires that providers have signed documentation of ANE in the record at the onset and then a conversation to occur thereafter. Human Rights would then expect to see a case note	

	documenting the discussion and that would be considered acceptable. As remediation, Human Rights can also add this expectation in their annual training to make sure people understand what they should be doing. QMR will discuss and review what they consider acceptable forms of documentation and then attempt to match that up with what Human Rights is doing. Discussion is needed to determine potential new data source for this PM for 2023 that can be tracked and remediated more effectively since data is not coming from OHR but QMR. This will be a topic moving forward with regard to changes that could be made to the performance measures and remediation activities for discussion in preparation for the 2023 waiver renewal.	
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 unavailable for meeting** **Update:** **For 4th Qtr. All Waivers Compliant** **PM Average All Waivers =Compliant** **EOY 2020/2021 = Compliant** **9265 / 9779 — 95%** **No remediation needed**	**Follow-up: None needed**

<table>
<tr><td>G6</td><td>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 unavailable at meeting

Update:

For 4th Qtr. All Waivers Compliant

PM Average All Waivers =Compliant
EOY 2020/2021 = Compliant
<table><tr><td>667</td><td rowspan="2">88%</td></tr><tr><td>755</td></tr></table>
No remediation needed</td><td>Follow-up: None needed</td></tr>
<tr><td>G9</td><td>Number and percent of participants 20 years and older who had an ambulatory or preventive care visit during the year.

FY 2020/2021 Compliance BI 12/17 (83.2%)

PM Average All Waivers
EOY 2020/2021 = Compliant
<table><tr><td>2,443</td><td rowspan="2">87%</td></tr><tr><td>2824</td></tr></table>
See related discussion below (G10)</td><td>Follow-up: See G10 below</td></tr>
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G10	**Number and percent of participants 19 and younger who had an ambulatory or preventive care visit during the year.** **For 4th Qtr. Compliance CL 585/868 (67.4%) FIS 570/907 (62.8%) BI 1/2 (50%)** **PM Average All Waivers** **EOY 2020/2021 = Noncompliant** **1,156 / 1727 — 67%** **Remediation:** This PM is noncompliant for the second year at 66% in 2020 and 67% in 2021. In the 2020 Evidence report, the QRT projected that the decrease was due to COVID and people delaying seeing a primary care physician. The PM was discussed together with G10 at some length. For PM G10, all waivers show low compliance for the quarter while G9 is in compliance for the quarter with the exception of the BI waiver. It was noted that national trends across the company do support the fact that people have delayed medical care (some nonemergency procedures actually were halted in states) during COVID. The MCO data used by the QRT for the PM serves as a proxy for the waiver populations (both children and adults) receiving an annual primary care, preventive exam. A challenge with using data originating from MCO's is that the QRT has had no input in determining the data elements used to screen the data for the PM and since the data is sent in aggregate at the end of the SFY, there is no way to impact compliance with a remediation intervention before the end of the reporting year. Insurance codes reviewed by the QRT previously indicated that other populations may be included in the data sent by the QRT AND preventive visits were being included that were not medical in nature (eye exams, etc.)	**Follow-up:** Investigate potential alternate data source from DBHDS OIH to be used as surveillance data.

	The QRT discussed data being used within DBHDS for DOJ compliance with a similar measure. There are several DBHDS Quality Improvement initiatives (QII's) developed that build off of a DOJ Performance Measurements Indicator (PMI) which has slightly different language than the QRT PM, but is intended to measure whether or individuals on the waiver are receiving an annual physical to identify/prevent health issues. Another QII/QIC approved for the Mortality Review Committee is targeting individuals at SIS level 6 for the purpose of reducing deaths due to cardiac disease. Since its approval, the workgroup has changed the goal of the task and the new QI strategy incorporates development of an annual physical form. Concern was expressed that if the QRT recommended remediation activities using data that is targeted to a different performance metric, the remediation would not have an impact on the PM percentages represented by the actual data being used. It was suggested that the data could be viewed as surveillance data to determine if it could be a relevant data source to include in the waiver renewal application in 2023. The OIH will continue to review the data for trends as presented in documentation sources. It was also noted that since the potential surveillance data originates from WaMS, there would need to be improvement in the information that is entered in WaMS by Support Coordinators, which is a training and enforcement issue. It was concluded that for the long term, the QRT should review the PM wording and data source for possible changes.	