FY 2022 2nd Qtr. QRT Meeting Summary
For QRT Meeting

3/30/2022 (rescheduled)

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 DD Policy and Compliance Manager 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
- Jessa Sprouse, DBHDS OIH Y or N
- Guest

	Agenda Item	Meeting Discussion	
I.	**Follow-up/ and global updates**		**Follow-up**

1.0	**Waiver Operations QRT TEAMS folder**	The QRT Manager provided a very quick demonstration of the QRT Teams Channel and the folder level structure where the QRT documents are housed. Other DBHDS or DMAS staff who need access to the QRT TEAMS channel should contact the QRT Manager.	**Follow-up:** As needed to ensure staff have access to the TEAMS channel.
2.0	**QRT App**	The QRT App testing scheduled for Feb 25-28 was delayed due to the need for additional programming. App deployment is still scheduled for the 2nd QTR Qtr. meeting (anticipated May 2022).	**Follow-up:** As needed with data SME's.
3.0	**Settlement Agreement Reporting**	The DBHDS DOJ Settlement Advisor gave a brief update on the DOJ Settlement Agreement via power point slide summary presentation. The slides were also presented during the Provider Roundtable and the CM Regional Meetings. The last DOJ reporting period was 12/2021. The Commonwealth gained four new provision compliance ratings in SFY 2021 despite significant systemic statewide barriers. Of 121 provisions monitored, 67% were compliant and 33% were non-compliant. The DOJ consultants conducted studies from 1/2022-April 2022 with the Independent Reviewer's report submission due to the court in June of 2022. The summary slides will be uploaded to the QRT 1st Qtr. Teams folder.	**Follow-up:** As needed
4.0	**Consolidated Evidence Report**	An Evidentiary Report summarizing state performance under the waiver assurances is sent to CMS every three years in advance of the waiver renewal. The state recently received an initial response from CMS to the 2021 Evidence Report requesting two quarters of additional data for the noncompliant PM's identified in the report. A reply to the request is being drafted to meet an April 25th due date and the data has already been pulled by DMAS for submission.	**Follow-up:** The QRT Manager will schedule a meeting with QRT subgroup in late Spring (3rd Qtr 2022) to begin the process of proposing and reviewing changes/new PM's for the next waiver renewal period (2023).

6.0	**Risk Awareness Tools: Continued Discussion**	The QRT has engaged in discussion the last few meetings regarding the DD risk awareness tools and other DBHDS initiatives that could be used to help identify risks. DMAS and DBHDS continue to work together to ensure consistency in the way that the RAT is used during QMR audits in place of the retired ARA tool. There will be continued discussion among QRT SME's regarding the types of data resulting from the use of these tools that can be reviewed by the QRT for possible future standardized reporting.	**Follow-up:** From meeting discussion the previous quarter, The OIH Director will share information from QMR reviews a with her team to develop a bulleted list of observational feedback to determine what can/should be shared with the QRT members for perspectives on next steps? The OIH Director will bring feedback to the next meeting.
7.0	**Mandatory Provider Remediation Process (MPR)T**	The QMR Supervisor provided a brief overview of the MPR process as it has been developed, to determine how it can be used to facilitate compliance with the performance measures. The MPR process has been referenced as a source of systemic remediation for noncompliance with waiver assurances. The major entry MPR points will be from QMR reviews, HCBS referrals and DBHDS OL providers receiving enhanced monitoring. Providers will be reviewed by a cross agency team which will review providers to determine if they meet criteria for the MPR. Providers who meet the process will receive prescribed remediation that must be completed and is based on the area of noncompliance. If a recommended remediation program has not been completed successfully, the provider will be notified and deemed noncompliant. Actions would begin to terminate the provider agreement with appeal rights given as required. Since both DMAS and Licensing have processes to remove providers from the DD system, these processes would either need to be synced, or the state would need to determine which process should be followed in the event a provider does not complete the process satisfactorily. The QRT was informed that the process	**Follow-up:** QRT Manager will forward the Zoom chat file to the QMR Supervisor. The QMR Supervisor will provide updates on the MPR process as a standing agenda item during each QRT meeting.

		will need to be reviewed by the DMAS OAG and DMAS Appeals prior to being implemented. The QMR Supervisor clarified that the MPR process, as designed, cannot be directly tied to the data submitted to the QRT for compliance with the performance measures; however, can be used to reflect systemic remediation as opposed to individual remediation. Due to time constraints it was determined that the QMR Supervisor would review the questions in the chat for future discussion. Updates on the MPR process will be a standing agenda item for QRT reporting moving forward.	
	Update PM/ Discussion: C8/C9 QII	**Background:** PM C8 and C9 relate to the required provider orientation and ensuring the competency of DSP staff. QRT data relies on QMR data to demonstrate both PM's. Since the QMR process is a documentation review and not an actual review of staff interactions with individuals in order to ensure competency, the DBHDS QII has been modified substituting QSR data for the data from QMR reviews to meet DOJ requirements. The QSR data now originates from the PCR alerts from HSAG with a secondary source of referrals referencing QMR CAPs. Since the QSR process already includes reviews of personnel files for compliance with DSP competencies, reviewers will observe provider personnel, review individuals' charts, and conduct interviews to determine what needs to be observed to ensure that staff are competent There is currently a mechanism in place to target technical assistance given to providers identified as not meeting standards	**Follow-up:** The Director of Provider Development is working with HSAG to determine how to classify provider personnel as incompetent, with these classifications of incompetence able to be shared with the DBHDS Internal QSR Review Team for mitigation. The QRT Manager will contact Provider Development for an update and to determine if there is data from the new QII. The previous QII involved targeted training. The QRT Manager will also follow up to determine if this training will be continued under the new QII.

		in the QMR reviews. This process can be redirected to QSR findings once those review elements are established. QMR data will remain as the data source for the PM with additional data from the QII potentially used as surveillance data.	
II.	***Review and Discussion of 1st Qtr. (7/1/2021-9/30/2021) QRT Data* (PM's with percentages reported below the 86% threshold for the Quarter).**		**Overall**, there is not much movement from the previous quarter (4th quarter). All of the same PM's are noncompliant, with a few additional noncompliant PM's. Further, noncompliance has tended to trend even higher than last quarter. Although different providers are reviewed each quarter, because we are seeing the same issues from quarter to quarter, year to year, these areas do seem to reflect problem areas.
C2	**Number & percent of licensed/certified waiver provider agency staff who have criminal background checks as specified in policy/regulation with satisfactory results.** **1st Qtr Compliance** **CL 140/146 (81.4%) (vs 84.9% previous quarter),** **CL 4 CAPS** • A SHINING LIGHT, INC. – some records not provided • LOUDOUN COUNTY CSB – not provided • NEW RIVER VALLEY COMMUNITY SERVICES – not completed b/c fingerprints weren't provided • OPEN HANDS LLC – not provided **Remediation:**		**Follow-up:** DMAS will follow up on options for capturing noncompliance with punitive actions. The QRT will continue observation of PM performance through the next quarter of 2022. **NOTE:** A correction to the PM should be made to the QRT chart (or data in the QRT APP).

	In many cases, compliance is directly related to the provider size and the specific providers included in the sample. Substantive discussion focused on =whether or not the state could institute financial penalties for repeated noncompliance. The randomly sampled DMAS audits for provider integrity not account for some of these areas of challenge and it is not being captured from that perspective. It is hoped that the auditors return to field work will help identify some of these issues so that providers can be issued payment retractions (paybacks). This will an area for continued discussion by the state. **NOTE:** A correction was made to the denominator reported for the CL waiver. The number should be 140/172 instead of 140/146. This correction should be made to the QRT chart (or data in the QRT APP).	
C5	**Number & percent of non-licensed/noncertified provider agency DSPs who have criminal background checks as specified in policy/regulation with satisfactory results.** **1st Qtr Compliance** **CL 1/2 (50%) (versus 40% previous Qtr.)** **1st Quarter** **CL 1 CAP** • Sugar Plum - No verification provided that CRC results indicate no barrier crimes **Remediation:** It was noted that this provider was the only provider with DSP's and so the small numbers greatly impacted compliance. In previous meetings, it was discussed that the service facilitator trainings have not kept pace with the types of issues that we are seeing with QRT reviews. It was recommended that DBHDS work with the DMAS Division of High Needs Support (Policy) to develop a reporting schedule for PM's with low compliance attributed to SF's to add to standardized trainings. The DMAS Policy	**Follow-up:** DBHDS and DMAS collaboration on additional training topics for SF providers and schedule for submission of the information for upcoming training modules. The DMAS Sr. Policy Analyst will follow up internally at DMAS and provide recommendations.

	analyst will reach out in his unit to determine the best time to receive recommended topics. This can be done at a regular intervals and also cover emergency issues. Topics could be included in SF modules and retakes, if necessary.	
C8	**Number and percent of provider agency staff meeting provider orientation training requirements.** **1st Qtr. compliance** **CL 109/158 (69%) (versus 80% previous quarter)** **FIS 7/9 (77.8%) (versus 75% previous quarter)** **1st Quarter** **CL 2 CAPs** • Alexandria CSB – not scored • A Shining Light- Not scored; missing **FIS 1 CAP** • Open hands – Not in record **Remediation:** See discussion in Section 1 update. It was noted that standard remediation practices (reminders during Provider Roundtable and e-mail notices sent) are ineffective because they are not targeted the providers who need to see and hear the information the most. QRT discussion focused again on whether provider paybacks would improve this long standing area of repeated noncompliance. **Update:** C8 and C9 are discussed together because previous remediation has focused on both the provider orientation and the competencies at the same time.	**Follow-up:** The QRT Manager will follow up to determine if there is surveillance data from the new QII (QSR alerts) around provider orientation. Follow up with DMAS regarding any changes to what is required as part of the CAP.

	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. The DOJ Settlement Advisory informed the QRT that the QSR tools and methodology have been updated recently, and as part of the new QII reviewers are sending alerts when they are seeing that this information is not in place. As a follow up to previous meeting discussion, the QRT discussed the utility of requiring providers to conduct a root cause analysis in conjunction with completion of the CAP. It was clarified that the process would not be the same as the RCA process used by Licensing, but would simply require the provider to identify where and how the failure occurred, so that the issue in question can be properly identified, and addressed with targeted training across providers. At present, DMAS does not have the resources or authority to implement RCA as it is used in Licensing but will consider adding some sort of explanation for the failure to the CAP that can be used for targeted interventions (training).	
C9	**Number and percent of provider agency direct support professionals (DSPs) meeting competency training requirements.** **1st Qtr. compliance** **CL 62/163 (38%) (versus 57% previous quarter)** **BI 2/3 (66.7%) (versus 50% the previous quarter)** **CAPS** **1st Quarter –** **CL 5 CAPS** • A SHINING LIGHT, INC. – No records provided, late annual updates • ALEXANDRIA COMMUNITY SERV BD – only signature page; proficiency not confirmed • LOUDOUN COUNTY CSB – missing 241 • OPEN HANDS LLC – annual not signed by DSP	**Follow-up:** The QRT Manager will follow up to determine if there is surveillance data from the new QII (QSR alerts) around DSP competencies, etc. See previous discussion in C8. DMAS Leadership will follow up with regard to the possibility of instituting payback for providers out of compliance with PM's.

	• ST COLETTA OF GREATER WASHINGTON INC – proficiency not confirmed, annuals late **BI 2 CAPS** • Azarel • St. Coletta – completed late **Remediation:** See discussion in Section 1 update and in PM C9. Instituting provider paybacks will be explored.	
D1	**Number and percent of individuals who have Plans for Support that address their assessed needs, capabilities and desired outcomes.** **1st Qtr. Compliance:** **CL 92/162 (56.8%) (versus 81.9% previous quarter)** **FIS 22/38 (57.9%) (versus 83.3 % previous quarter)** **BI 5/6/ (83.3%) (versus 76.5% previous quarter)** **1st Quarter** **CL 10 CAPS** • A SHINING LIGHT, INC – Specific SN needs; seizure, behaviors, etc. • ALEXANDRIA COMMUNITY SERV BD – pressure injury, dehydration, bowel obstruction, etc. • AZAREL COMMUNITY SUPPORT, LLC – fall risk, dehydration, behaviors, etc. • BLESSED HANDS AND HEART, LLC – pressure injury, dehydration • EXCEPTIONAL MATTERS LLC – prevention of injury/assault to others • LOUDOUN COUNTY CSB- aspiration pneumonia, fall w/ injury, dehydration, sepsis	**Follow-up:** DBHDS Policy, DMAS QMR OIH and Provider Development will need to schedule a future meeting to review the use of the RAT in provider reviews and to schedule specific remediation/mitigation for areas D1, D3, and D6. DMAS Leadership will follow up with regard to the possibility of instituting paybacks for providers out of compliance with PM's.

	• NEW RIVER VALLEY COMMUNITY SERVICES - Pressure injury, , falls, dehydration bowel obstruction, sepsis, etc. • SPECIAL CARE SERVICES LLC - protect infectious diseases, therapy services, high cholesterol, vision, Sic Sinus syndrome-Pacemaker, emotional outbursts, wandering, PTSD, fall. • ST COLETTA OF GREATER WASHINGTON INC pressure injury, dehydration, bowel obstruction, sepsis, & seizure disorder • SUGAR PLUM BAKERY emotional outburts identified **FIS 6 CAPS** • EXCEPTIONAL MATTERS LLC - behaviors • LOUDOUN COUNTY CSB – extensive supports w/ preventing wandering and food seeking ; bowel obstruction/constipation • NEW RIVER VALLEY COMMUNITY SERVICES - Seizures and choking; self-harm • OPEN HANDS LLC – safety supports; behaviors • SPECIAL CARE SERVICES LLC – elopement, seizures **BI 1 CAP** • ST COLETTA OF GREATER WASHINGTON INC – seizures **Remediation:** A downward trend for the PM continues for this PM. 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. During previous meetings, several internal processes and groups were referenced that capture information on health and safety needs. It was noted during the meeting that an additional source of information could be information captured as part of the ISP 3.3, which went live on 5/1 and which can be tied back to the SC onsite visit tool and other risk tools. The new ISP 3.3, attempts to collect medical history was revised to have the SC's focus on listing medical dx in one category and psychiatric dx on a separate list, hospitalization, breaking out health protocols in a separate list. History and current active supports needed to all be in once place in order to be traced through and ISP. The MRC needs the information to identify if all the supports were in place to safely care for in individual during the three months preceding a death.	
D3	**Number and percent of individuals whose Plan for Supports includes a risk mitigation strategy when the risk assessment indicates a need.** **1st Qtr. Compliance:** **CL 60/111 (54.1%) (versus 79.3% previous quarter)** **FIS 11/25 (44%) (versus 71.9% previous quarter)** **BI 1/2 (50%) (versus 40% pervious quarter)** **1st Quarter** **CL 10 CAPS** • A SHINING LIGHT, INC – Specific SN needs; seizure, behaviors ., etc. • ALEXANDRIA COMMUNITY SERV BD – pressure injury, dehydration, bowel obstruction, etc. • AZAREL COMMUNITY SUPPORT, LLC – fall risk, dehydration, behaviors, etc. • BLESSED HANDS AND HEART, LLC – pressure injury, dehydration • EXCEPTIONAL MATTERS LLC – prevention of injury/assault to others • LOUDOUN COUNTY CSB- aspiration pneumonia, fall w/ injury, dehydration, sepsis	**Follow-up:** See previous discussion Section I Agenda item 6.0 DBHDS Policy, DMAS QMR OIH and Provider Development will need to schedule a future meeting to review the use of the RAT in provider reviews and to schedule specific remediation/mitigation for areas D1, D3, and D6. DMAS Leadership will follow up with regard to the possibility of instituting paybacks for providers out of compliance with PM's

	• NEW RIVER VALLEY COMMUNITY SERVICES - Pressure injury, , falls, dehydration bowel obstruction, sepsis, etc. • SPECIAL CARE SERVICES LLC - protect infectious diseases, therapy services, high cholesterol, vision, Sic Sinus syndrome-Pacemaker, emotional outbursts, wandering, PTSD, fall. • ST COLETTA OF GREATER WASHINGTON INC pressure injury, dehydration, bowel obstruction, sepsis, & seizure disorder • SUGAR PLUM BAKERY emotional outbursts identified **FIS 6 CAPS** • EXCEPTIONAL MATTERS LLC - behaviors • LOUDOUN COUNTY CSB – extensive supports w/ preventing wandering and food seeking ; bowel obstruction/constipation • NEW RIVER VALLEY COMMUNITY SERVICES - Seizures and choking; self-harm • OPEN HANDS LLC – safety supports; behaviors • SPECIAL CARE SERVICES LLC – elopement, seizures **BI 1 CAP** • St Coletta - Fall with injury **Remediation:** A downward trend for the PM continues as it has for the past several years. Se previous remediation discussion in Section I with regard to instating provider paybacks.	
D6	**Number and percent of individuals whose service plan was revised, as needed, to address changing needs.** **1st Qtr. Compliance:** **CL 13/19 (68.4%) (versus 52.5% previous quarter)** **FIS 2/3 (66.7%) (compliant previous quarter)**	**Follow-up:** DBHDS Policy, DMAS QMR OIH and Provider Development will need to schedule a future meeting to review the use of the RAT in provider reviews and to schedule specific remediation/mitigation for areas D1, D3, and D6.

	1st Quarter **CL 4 CAPS** • A SHINING LIGHT, INC. RNs not documenting amount of time spent with individual; multiday PN, not provided as scheduled • AZAREL COMMUNITY SUPPORT, LLC –not offered number of days scheduled; no attendance logs • OPEN HANDS LLC – no times in or out • ST COLETTA OF GREATER WASHINGTON INC outcome not offered # of day s scheduled **FIS 1 CAP** • Open hands – no current schedule; not provided according to schedule **Remediation:** The PM has a long standing history of lower performance. See previous remediation discussion. **During the last meeting 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 will apply the protocol to sample providers to determine where that provider would fit into the table indicating the threshold for mandatory remediation. D1, D3, D6, – additional discussion and action needed.	DMAS Leadership will follow up with regard to the possibility of instituting paybacks for providers out of compliance with PM's
D10	**Number and percent of individuals who received services in the scope specified in the service plan**	**Follow-up:** The QRT Manager will review the previous quarter's PM data to confirm or deny the presence of similar

	This is actually a new PM that is identified as noncompliant. **1st Qtr. Compliance:** **CL 88/106 (83.06%) (compliant previous quarter)** **1st Quarter** **CL 1 CAP** • A Shining Light – skilled nursing not provided **Remediation:** The example referenced included skilled nursing issues. The QRT Manager will review the previous quarter's PM data to confirm or deny the presence of similar skilled nursing errors. If previous quarter noncompliance also shows skilled nursing issues, this could result in a memo that is distributed to provider. It was also suggested that an update could be made to the TSADF Grid adding new examples of noncompliance recently observed. If not, the QRT will continue to review the data for two quarters to determine if the noncompliance is an anomaly.	skilled nursing errors. If not, the QRT will continue to review the data for two quarters to determine if the noncompliance is an anomaly.
D11	**Number and percent of individuals who received services in the amount specified in the service plan** **1st Qtr. Compliance:** **CL 71/106 (67%) (compliant previous quarter)** **FIS 6/16 (37.5%) (compliant previous quarter)** **1st Quarter** **CL 4 CAPS**	**Follow-up:** TBD

	• A SHINING LIGHT, INC. RNs not documenting amount of time spent with individual; no documentation of services • AZAREL COMMUNITY SUPPORT, LLC –not offered number of days scheduled • OPEN HANDS LLC – no times in or out; not offered per schedule • ST COLETTA OF GREATER WASHINGTON INC outcome not offered # of day s scheduled **FIS 2 CAPS** • BLESSED HANDS AND HEART, LLC - aid not in place • OPEN HANDS LLC no current schedule; no provided according to schedule **Remediation:** The examples referenced are skilled nursing issues. See previous PM discussion above. It was also noted that OIH and SA, with Provider Development input and vetting by DMAS, built a training on skilled nursing that will be delivered to providers tomorrow. The training will be on a quarterly rotation and be saved to the COV CLC for future access. The training resulted from the Nursing Services Workgroup and can be referenced as a remediation activity. An update to the TSADP Grid can be developed if noncompliance persists.	
D13	**Number and percent of individuals whose case management records contain an appropriately completed and signed form that specifies choice was offered among waiver services** **1st Qtr. Compliance:** **B1 3/4 (75%) (compliant previous quarter)** **1st Quarter** **BI 1 CAP**	**Follow-up:** TBD

	• Loudon CO – information not provided **Remediation:** This is a PM that has not been noncompliant in several years. The CSB provider represented case management. There were only 4 records in the sample; however, one noncompliant record significantly impacted the percentage as the numbers in the BI waiver are much smaller. During discussion, it was determined that the noncompliance this quarter is likely an anomaly that can be monitored over a few quarters to determine if the issue resolves itself.	
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.** **Measure is in compliance for the quarter 67/75 (89%)** **Remediation:** Annual compliance for 2021 was at 85%. It was noted that remediation is occurring which includes ANE and CHRIS training for providers that incorporates how the performance measures and the investigations are tied together and so the numbers have improved this quarter. However, this is the last quarter that the QRT will have data for this PM. 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. As DQV prepared for the next round of the Community Look Behind (reviewing cases in FY22), a substantial barrier was encountered that must be addressed. DQV identified a data quality issue in the Office of Licensing Information	**Follow-up:** Internal conversations needed within DBHDS and DMAS to discuss cessation of the community look behinds and replacement data. Recommended QRT Manager follow up with DHDS Quality as this data issue may have been resolved or in the process of being resolved.

	System (OLIS) that extended to CHRIS and the Data Warehouse tables. On September 1, 2021, DQV communicated to DBHDS leadership and key stakeholders that there does not appear to be a single comprehensive source of information classifying services by diagnosis group (i.e. DD, MH, SA, BI). All of the lookup tables in OLIS, CHRIS, and the Data Warehouse lack complete information related to which program and service codes specialize in supporting individuals with DD. Without a means of distinguishing between DD and non-DD services, the sample of abuse, neglect, and exploitation cases retrieved from CHRIS may not be representative of all DD services. Rather, the sample would be representative of a subset of DD services that systematically excludes other DD services solely due to data quality errors. Without a clear way to group the program and service codes associated with DD services, it is not possible for DQV to retrieve a valid random sample of Human Rights allegations for DD services. This issue must be addressed in the source system (OLIS) and incorporated into CHRIS before the Community Look Behind reviews can proceed. To this end, the Community Look Behind is postponed until a valid and reliable list of services and the populations they support is available in DBHDS's licensing system of record and properly integrated in CHRIS and the Data Warehouse. There is no ETA and it is not known when there will be data. The pause in data collection will not change how Human Rights supports investigations; however, it does impact PM reporting for this measure. It was mentioned that this is being discussed within DBHDS and a resolution may have been reached. The QRT Manager will follow up as needed.	

G4.	Number and percent of individuals who receive annual notification of rights and information to report ANE. **For 1st Qtr. Compliance** **CL 94/113 (84%) (versus 55.9% previous quarter)** **BI 5/6 (83.3%) (versus 70.6% previous quarter)** **1st Quarter** **CL 4 TAs** • A shining Light – missing/not annual • Loudon CSB – missing/not annual • New River CSB – not signed by individual • St Coletta – missing/not annual **BI 1 TAs** • Loudon CSB-did not provide **Remediation:** Additional remediation needed. 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	**Follow-up:** Follow up with DMAS to incorporate synch acceptable documentation between DMAS and OHR for ANE reporting.

	consider acceptable forms of documentation and then attempt to match that up with what Human Rights is doing. 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.	
G6	**Number and percent of licensed DD providers that administer medications that were not cited for failure to review medication errors at least quarterly.** **Data not provided**	**Follow-up: Needed**