SFY2023 Mortality Review Committee Charter
QIC Approved 9.21.22

Committee	Mortality Review
Statement of Purpose	The purpose of the DBHDS Developmental Disabilities (DD) Mortality Review Committee (MRC) is to focus on system-wide quality improvement by conducting mortality reviews of individuals who were receiving a service licensed by DBHDS at the time of death and diagnosed with an intellectual disability and/or developmental disability (I/DD), utilizing an information management system to track the referral and review of these individual deaths.
Authorization / Scope of Authority	The DBHDS Commissioner is the executive sponsor of the MRC and designates the Chief Clinical Officer (CCO) to establish and supervise the Mortality Review Office (MRO). Through the DBHDS incident reporting system, and in collaboration with the Office of Licensing, the MRC reviews deaths of individuals with I/DD who received a service licensed by DBHDS at the time of death. The MRC is a sub-committee of the Quality Improvement Committee (QIC). The MRC provides ongoing monitoring and data analysis to identify trends and/or patterns and then makes recommendations to promote the health, safety and well-being of said individuals. To the best of its ability, the MRC will determine the cause of an individual's death, whether the death was expected, and if the death was potentially preventable. The MRC also develops and assigns specific relevant actions when needed.
Charter Review	The MRC charter is reviewed and/or revised on an annual basis, or as deemed necessary by the committee and approved by the QIC.
DBHDS Quality Improvement Standards	DBHDS is committed to a Culture of Quality that is characterized as: • Supported by leadership • Person Centered • Led by staff who are continuously learning and empowered as change agents • Supported by an infrastructure that is sustainable and continuous • Driven by data collection and analysis • Responsive to identified issues using corrective actions, remedies, and quality improvement initiatives (QIIs) as indicated DBHDS demonstrates on an on-going basis that it identifies, addresses, and seeks to prevent instances of abuse, neglect, exploitation and unexplained death. DBHDS develops and implements QIIs, either regionally or statewide, as recommended by the MRC and approved by the DBHDS Commissioner, to reduce mortality rates to the fullest extent practicable.

Model for Quality Improvement	On a quarterly basis, DBHDS staff assigned to implement QIIs will report data related to the QIIs to the MRC to enable the committee to track implementation. Through mortality reviews, data collection, and analysis of data, including trends, patterns, and problems at individual service delivery and systemic levels, the MRC identifies areas for development of QIIs. Data reviews occur as part of quality improvement activities and as such are not considered research. To that end, the committee determines the: • Aim: What are we trying to accomplish? • Measure: How do we know that a change is an improvement? • Change: What change can we make that will result in improvement? Implements the Plan/Do/Study/Act Cycle: • Plan: Defines the objective, questions and predictions. Plan data collection to answer questions. • Do: Carry out the plan. Collect data and begin analysis of the data. • Study: Complete the analysis of the data. Compare data to predictions. • Act: Plan the next cycle. Decide whether the change can be implemented. Additionally, the MRC: • Establishes performance measure indicators (PMIs) that align with the eight domains when applicable • Monitors progress towards achievement of identified PMIs and for those falling below target, determines actions that are designed to raise the performance • Assesses PMIs overall annually and based upon analysis, PMIs may be added, revised or retired in keeping with continuous quality improvement practices. • Utilizes approved system for tracking PMIs, and the efficacy of preventive, corrective and improvement measures • Develops and implements preventive, corrective and improvement measures where PMIs indicate health and safety concerns • Share data or findings with quality subcommittees when significant patterns or trends are identified and as appropriate to the work of the subcommittee • Utilizes data analysis to identify areas for improvement and monitor trends; identifies priorities and recommends QIIs as needed • Implements approved QIIs within 90 days of the date of approval • Monitors progress of approved QIIs assigned and addresses concerns/barriers as needed • Evaluates the effectiveness of the approved QII for its intended purpose • Demonstrates annually at least 3 ways in which data collection and analysis has been used to enhance outreach, education, or training

	• Completes a committee performance evaluation annually that includes the accomplishments and barriers of the MRC
Structure of Committee:	
Membership	The MRC is composed of members with training and experience in the areas of I/DD, including but not limited to: Clinical expertise, Medical and pharmacy services, Quality improvement, Compliance, Incident management, Behavior analysis, and Data analytics. Required Mortality Review Committee DBHDS members include: • Chief Clinical Officer *(MD, and staff member with QI and programmatic/operational [P/O] expertise)* • Assistant Commissioner of Developmental Services, or designee *(staff member with QI and P/O expertise)* • Director, Compliance Management, or designee *(staff member with QI, P/O, and regulatory expertise)* • Senior Director, Office of Clinical Quality Management *(staff member with QI andP/O expertise)* • Director, Office of Community Quality Management, or designee *(Clinician or staff member with QI and P/O expertise)* • Director, Office of Human Rights, or designee *(staff member with regulatory, QI and P/O expertise)* • Director, Office of Integrated Health, or designee *(staff member with QI and PO expertise)* • MRO Clinical Manager, MRC Co-Chair (*NP and staff member with QI and P/O expertise*) • OL Manager, Investigation Team *(staff member with regulatory and P/O expertise)* • Office of Pharmacy Services Manager *(PharmD and staff member with regulatory, QI and P/O expertise)* • MRO Clinical Reviewer *(RN and staff member with QI and P/O expertise)* • MRO Program Coordinator *(Staff member with QI and P/O expertise)* • A member with clinical experience to conduct mortality reviews who is otherwise independent of the State *(medical doctor, nurse practitioner, or physician assistant, who is an external member with P/O expertise)* Advisory *(non-voting members*) nominated by the Commissioner or Chair of the MRC, which may include; • Deputy Commissioner, Policy & Public Affairs, or designee • Settlement Agreement Advisor • Representative, DBHDS Office of Epidemiology and Health Analytics • Representative, DBHDS Office of Licensing's Investigative Management Unit (IMU) • Representative, Department of Medical Assistance Services • Representative, Department of Health • Representative, Department of Social Services • Representative, Office of Chief Medical Examiner

	• Representative, Community Services Board • Other Subject matter experts such as representatives from a DD Provider or Advocacy Organizations
Meeting Frequency	The MRC meets virtually, at minimum, bi-monthly or more frequently as necessary to conduct mortality reviews with 90 days of death. Meetings can occur in the absence of quorum; however, no deliberations can be taken during these meetings. Additional workgroups may be established as needed.
Quorum	A quorum is 50% of voting membership plus one, with attendance of at least: (One member may satisfy two roles) • A medical clinician (*medical doctor, nurse practitioner, or physician assistant*) • A member with clinical experience to conduct mortality reviews • A professional with quality improvement expertise • A professional with programmatic/operational expertise Quorum status is monitored throughout the meeting with verification of quorum status before voting on these deliberations that require quorum: approval of minutes, subcommittee recommendations to the QIC, approval/denial of quality improvement initiative (QII), PMIs (new, revisions, ending), and charters.
Leadership and Responsibilities	The DBHDS Commissioner shall serve as the executive sponsor of the MRC and the CCO, or Clinical Manager (CM), shall serve as committee chair. The committee chair shall be responsible for ensuring the committee performs its functions, consideration and, as appropriate, approval of quality improvement activities, and MRC core processes. <u>Standard operating procedures</u>: • The Specialized Investigation Unit (SIU) reviews all deaths of individuals with I/DD reported to DBHDS through its incident reporting system. Available records and information are obtained for individuals with I/DD who were receiving a licensed service, and the OL Investigation (OLI) is submitted to the MRO within 45 business days (9 weeks) of the date the death was reported. • The MRO then has 13 days after receipt of the OLI to compile a case review. Within 90 calendar days of a death, (and for any unreported deaths, as defined on page 6), the Mortality Review Team (MRT) composes a review summary of the death. This includes development of succinct clinical case summaries (definition page 11) within two weeks of reviewing and documenting the availability or unavailability, of: ♦ Medical records: Including healthcare provider and nursing notes for three months preceding death ♦ Incident reports for three months preceding death ♦ Most recent individualized service program plan ♦ Medical and physical examination records ♦ Death certificate and autopsy report (when performed) ♦ Any evidence of maltreatment related to the death ♦ Interviewing, as warranted, any persons having information regarding the individual's care ♦ When additional documents are needed, the MRT will request these records from appropriate entities per Virginia Code §§2.2-3705.5, 2.2-3711, and 2.2-4002 amendment of the Virginia Code

- The Clinical Reviewers compose a succinct clinical case summary from reviews of all documents submitted by OL, records all relevant information onto the electronic Mortality Review Form (eMRF), and submits each clinical case summary for MD/NP appraisal. The CCO (MD) or CM (NP) reviews all clinical case summaries and assigns a Tier category based on the sequential information related to the events surrounding that individual's death. Additional information is requested if needed, to clarify or expand the sequence of events leading to an individual's death. The criteria for each Tier category is also utilized. These cases are then considered final clinical summaries (see Definitions, page 11). A facilitated discussion is conducted during MRC meetings for all Tier 1 cases and those cases where the Tier category could not be determined without MRC discussion and decision-making.
- To ensure confidentiality and adhere to mandated privacy regulations and guidelines, case reviews are provided to MRC members during the meeting only. At that time, a facilitated narration with discussion occurs.

<u>At each meeting the MRC members:</u>

- ♦ Perform comprehensive clinical mortality reviews utilizing a multidisciplinary approach that addresses relevant factors *(e.g., medical, genetic, social, environmental, risk, susceptibility, and others as specific to the individual)* and quality of service.
- ♦ Evaluate the quality of the decedent's licensed services related to disease, disability, health status, service use, and access to care, to ensure provision of a reliable, person-centered approach.
- ♦ Identify risk factors and gaps in service and recommend quality improvement strategies to promote safety, freedom from harm, and physical, mental and behavioral health and wellbeing.
- ♦ Review OL Corrective Action Plans (CAPs) related to required recommendations, to ensure no further action is required and for inclusion in meetingminutes.
- ♦ Make additional recommendations for further investigation and/or actions by other DBHDS Offices represented by MRC members, as appropriate.
- ♦ Assign these recommendations and/or actions to specific MRC member(s) as appropriate.
- ♦ Review and track the status of previously assigned recommended actions to ensure completion.
- ♦ The committee may also interview any persons having information regarding the individual's care.

For each case reviewed, the MRC seeks to identify:

- The cause of death (CoD)
- If the death was expected (XP)
- Whether the death was potentially preventable (PP)
- Any relevant factors impacting the individual's death
- Any other findings that could affect the health, safety, and welfare of these individuals
- Whether there are other actions that may reduce these risks, to include provider training and communication regarding risks, alerts, and opportunities for education (see Definitions under "Leadership and Responsibilities" section).

- If any actions are identified based on the case review, the MRC will then make and document relevant recommendations and/or interventions
- Documentation is located in the Meeting minutes, Notes Summary, Action Tracking Log, and/or on the eMRF

The MRC will make recommendations *(including but not limited to, QIIs)* in order to reduce mortality rates to the fullest extent practicable.

- The case may be closed or pended. If all determinations are made, the case is closed by the committee. If additional information is needed in order to make a determination, the case is pended until the next meeting.
- Cases that are pended are considered reviewed within 90 days of the individual's death based on the beginning review date.
- A pended case remains open until the following meeting, when the designated committee member provides an update, or specific information has been received, as requested. If all determinations are made, the pended case is closed by the committee.

- Monthly, for quality assurance purposes and to attempt to identify deaths that were not reported through DBHDS' incident reporting system:
  - The MRO provides a list of identifying information for I/DD individuals in the Waiver Management System who received DBHDS-licensed services to the Virginia Department of Health (*VDH*)
  - VDH identifies names from that list for which a death certificate is on file and provides results back to the MRO.
  - The MRO forwards the information to the DBHDS OL SIU Manager, who researches DBHDS' incident reporting systems to determine if the individual was receiving a DBHDS licensed service at the time of death and therefore was not reported by a DBHDS licensed provider. SIU team investigates all unreported deaths identified by this process and takes appropriate action in accordance with DBHDS licensing regulations and protocols.
  - Upon completion of the OL investigation, if a death is determined to require MRC review, the MRT will initiate the usual review process for the case as per current standard operating procedure (see pages 5 &6).

- The MRC documents recommendations for systemic QIIs coming from patterns of individual reviews on an ongoing basis, and analyzes patterns that emerge from any aggregate examination of mortality data for cases that were reviewed by the MRC on an ongoing basis.
  - From this analysis, the MRC makes one recommendation per quarter *(four recommendations/year)* for systemic QIIs, and reports these recommendations to the QIC (*quarterly*) and the DBHDS Commissioner *(annually*).
  - The MRC prepares and delivers to the DBHDS Commissioner a report of deliberations,

findings, and recommendations, if any, for 86% of deaths requiring review within 90 days of the death. If the MRC elected not to make any recommendations, documentation will affirmatively state that no recommendations were warranted.

- The MRC prepares an annual report of aggregate mortality trends and patterns for all individual deaths that occurred in the state fiscal year and that were also reviewed by the MRC, within six months of the end of the fiscal year. A summary of the findings is released publicly.

- Provides relevant data (statewide aggregate) to the RQCs which includes comparisons to other internal or external data as appropriate and includes multiple years as available, at least on an annual basis

<u>Membership responsibilities:</u>

Pursuant to Virginia Code § 37.2-314.1, all MRC members and other persons who attend closed meetings of the MRC are required to sign a confidentiality agreement form. Members shall notify the MRC Co-Chair and/or MRO Program Coordinator prior to having a guest attend a meeting so that arrangements may be made for the guest to sign the confidentiality agreement form before (s)he is permitted to attend. Guests should attend only relevant portions of the MRC with limited access to PHI and other sensitive case information. Member confidentiality forms are valid for the entire term of MRC membership, and guest confidentiality forms are valid for repeat attendance at MRC meetings. New members will receive training within 30 business days of joining the committee.

All members adhere to agency policy and procedure related to HIPAA compliance and protection of confidential information (DI 1001 – Privacy Policies and Procedures for the Use and Disclosure of PHI).

- All MRC members must receive training that includes:
  - Orientation to the MRC charter to educate the member on the scope, mission, vision, charge, and function of the MRC
  - Review of the policies, processes, and procedures of the MRC
  - Education on the role/responsibility of the member(s)
  - Training on continuous quality improvement principles

- **Voting members:**
  - Have decision making capability and voting status.
  - Attend 75% of meetings per year and may send a designee that is approved by the MRC chair (*or Co-Chair*) prior to the meeting.
  - Review data and reports for meeting discussion.
  - May send a designee to MRC meetings but should attend at least one meeting per quarter. The designee shall have decision-making capability and voting status, and should come prepared for the

	meeting. ♦ Absence is considered excused if the member has notified the MRC Co-Chair or MRO Program Coordinator prior to the meeting that the member and/or designee are unable to attend. ♦ Recognize that an excused absence does not contribute to the 75% attendance requirement. • **Advisory members:** ♦ Are non-voting stakeholder members selected and approved by the QIC and DBHDS Commissioner whose various perspectives provide insight on MRC reviews, clinical insight, medical expertise, and MRC performance goals, outcomes, required and recommended actions. ♦ Inform the committee by identifying and prioritizing MRC decision making and recommendations. ♦ May be appointed for a term of two (2) years, and may be reappointed as ex-officio member ♦ Are expected to attend one meeting every quarter (4/year), and may send a designee whom is approved by the MRC chair prior to the meeting. An absence is considered excused if the advisory member has notified the MRC Co-Chair or MRO Program Coordinator prior to the meeting, that the advisory member and/or designee are unable to attend. ♦ Recognize that an excused absence does not contribute to the attendance requirement.
Recusal	Members must recuse themselves from MRC proceedings if a conflict of interest (COI) arises, in order to maintain neutrality *(prevent bias)* and credibility of the MRC mortality review process. COI exists when an MRC member has a financial, professional or personal interest that could directly influence MRC determinations, findings or recommendations, such as: • The MRC member, or an individual from the member's family, was actively involved in the care of the decedent *(direct care r/t employment or financial as listed below*) • The MRC member may have participated in a facility or institutional mortality review of the decedent • The MRC member, or an individual from the member's family, has a financial interest or investment that could be directly affected by the mortality review (*including determinations and recommendations*) of the decedent, to include employment, property interests, research, funding or support, industry partnerships and consulting relationships Should a COI arise during the review process, the MRC member will: • Immediately disclose the potential COI and cease participation in the case review related to the existing or potential COI • Disclose the COI privately to the Chair/Co-Chair, or publicly to the members in attendance. The MRC will then halt discussion of the COI case, move on to the next case and place the COI case at the end. This allows the MRC member with a COI to remain for the review of other cases, and then leave the proceedings prior to the discussion of the COI case.

Definitions	• Comprehensive clinical case summaries (CCS) denotes an in-depth inclusive review of clinical and sequential information related to the events surrounding the individual's death. After review/appraisal by the CCO or CM, CCS' are assigned a Tier category and considered final CCS. These may be reassigned at the recommendation of the MRC. • Tier 1 case criteria: A case is categorized as Tier 1 when any of the following criteria exists: ♦ Cause of death cannot clearly be determined or established, or is unknown ♦ Any unexpected death *(such as suicide, homicide or accident*). This includes any death that was: not anticipated or related to a known terminal illness or medical condition, related to injury, accident, inadequate care or associated with suspicions of abuse or neglect. A death due to an acute medical event that was not anticipated in advance nor based on an individual's known medical condition(s) may also be determined to be an unexpected death. ♦ Abuse or neglect is specifically documented ♦ Documentation of investigation by or involvement of law enforcement or similar agency (*including forensic)* ♦ Specific or well-defined risks to safety and well-being are documented. • Tier 2 case criteria: A case is categorized as Tier 2 when all the first 4 criteria exists: ♦ Cause of death can clearly be determined or established ♦ No documentation of abuse or neglect ♦ No documentation of investigation by or involvement of law enforcementor similar agency (*including forensic*) ♦ No documentation of specific or well-defined risks to safety and well-being are noted. ♦ An expected death that occurred as a result of a known medical condition, anticipated by health care providers to occur as a result of that condition and for which there is no indication that the individual was not receiving appropriate care. ♦ An unexpected (unexplained) death that occurred as a result of a condition that was previously undiagnosed, occurred suddenly, or was not anticipated. This includes any death that was: not anticipated or related to a known terminal illness or medical condition, related to injury, accident, inadequate care or associated with suspicions of abuse or neglect. A death due to an acute medical event that was not anticipated in advance nor based on an individual's known medical condition(s) may also be determined to be an unexpected death. • Expected Death denotes a death that occurred as a result of a known medical condition, anticipated by

health care providers to occur as a result of that condition and for which there is no indication that the individual was not receiving appropriate care. Clear evidence that the individual received appropriate and timely care for the medical condition exists.

- Unexpected Death denotes a death that occurred as a result of a condition that was previously undiagnosed, occurred suddenly, or was not anticipated. Deaths are considered unexpected when they: are not anticipated nor related to a known terminal illness or medical condition; are related to injury, accidents, inadequate care; or are associated with suspicions of abuse or neglect. An acute medical event that was not anticipated in advance nor based on an individual's known medical condition(s) may also be determined to be an unexpected death. An unexplained death is considered an unexpected death.

- Unknown indicates there is insufficient information to classify a death as either expected or unexpected or there is insufficient information to make a determination as to the cause of death.

- Other (Cause of Death) denotes a cause of death that is not attributable to one of the major causes of death used by the MRC for data trending.

- Potentially Preventable (PP) Deaths denotes deaths in the opinion of the MRC that might have been prevented with reasonable valid intervention (*e.g., medical, social, psychological, legal, educational*). If the individual was provided with known effective medical treatment or public health intervention and died despite this provision of evidenced based care, the death is not considered potentially preventable. A death may be determined to be PP regardless of whether the death is actionable by DBHDS or within the control of DBHDS. Deaths that occur in settings that are not licensed by DBHDS may be PP deaths. Deaths that do not indicate a violation of a licensing standard may be PP. Deaths determined to be PP have identifiable actions or care measures that should have occurred or been utilized. When the MRC determines a death is PP, the committee categorizes factors that might have prevented the death. For a death to be determined PP, the actions and events immediately surrounding the individual's death must be related to deficits in the timeliness or absence of, at least one of the following factors:
    - Coordination and optimization of care
    - Access to care, including delay in seeking treatment
    - Execution of established protocols
    - Assessment of, and response to, the individual's needs or change in status

- For actions recommended by the MRC, the MRC shall consider if one of the following prevention strategies may be utilized:
    - ♦ Primary Prevention Strategies—Educational and changes to services designed to help prevent a condition or event from taking place, that have been found to contribute to morbidity or mortality, such as education on reducing falls
    - ♦ Secondary Prevention Strategies—Focus on early detection and timely treatment of conditions or injuries to minimize harmful effects and prevent further morbidity or mortality, such as interventions that support and promote cancer screening
    - ♦ Tertiary Prevention Strategies—Optimization of the treatment and management of conditions or injuries, such as ensuring access to evidence-based treatment

- Two data formats that are utilized;
    - Reviewed – denotes actual cases presented to and discussed by the MRC in a specified timeframe, which may include a death that happened at any point in time
    - Occurred – denotes only deaths that transpired during a specified timeframe

The following standard definitions as referenced in Part I of the Quality Management Plan (*Program Description)* are established for all quality committees:

- Advising Members - Members of the quality committees without the authority to approve meeting minutes, charters, PMIs and other activities requiring approval.
- Corrective Actions - DBHDS OL imposed requirements to correct provider violations of Licensure regulations
- Data Quality Monitoring Plan - Ensures that DBHDS is assessing the validity and reliability of data, at least annually, that it is collecting and identifying ways to address data quality issues.
- Eight Domains - Outline the key focus areas of the DBHDS quality management system (QMS): (1) safety and freedom from harm; (2) physical, mental and behavioral health and well-being; (3) avoiding crises; (4) stability; (5) choice and self-determination; (6) community inclusion; (7) access to services; and (8) provider capacity.
- Home and Community-Based Services (HCBS) Waivers - provides Virginians enrolled in Medicaid long-term services and supports the option to receive community-based services as an alternative to an institutional setting. Virginia's CMS-approved HCBS waivers include the Community Living (CL) Waiver, the Family and Individual Supports (FIS) Waiver, and the Building Independence (BI) Waiver.
- Key Performance Area (KPA) - DBHDS defined areas aimed at addressing the availability, accessibility, and quality of services for individuals with developmental disabilities. These areas of focus include

	Health, Safety and Well-Being; Community Inclusion and Integration; and Provider Competency and Capacity. • Key Performance Area Workgroups - DBHDS workgroups that focus on ensuring quality service provision through the establishment of performance measure indicators, evaluation of data, and recommendation of quality improvement initiatives relative to the eight domains. • N - Sample size • National Core Indicators - Standard performance measures used in a collaborative effort across states to assess the outcomes of services provided to individuals and families and to establish national benchmarks. Core indicators address key areas of concern including employment, human rights, service planning, community inclusion, choice, health and safety • Performance Measure Indicators (PMIs) - Include both outcome and output measures established by the DBHDS and reviewed by the DBHDS QIC. The PMIs allow for tracking the efficacy of preventative, corrective and improvement initiatives. DBHDS uses these PMIs to identify systemic weaknesses or deficiencies and recommends and prioritizes quality improvement initiatives to address identified issues for QIC review. • Quality Committees - The QIC and QIC Subcommittees collectively • Quality Improvement Committee (QIC) Subcommittee/Quality Committee - DBHDS quality committees, councils and workgroups existing as part of the QMS (Case Management Steering Committee, Key Performance Area Workgroups, Mortality Review Committee, Regional Quality Councils, and the Risk Management Review Committee). • Quality Improvement Committee (QIC)-Oversees the work of the QIC subcommittees • Quality Improvement Initiative - Addresses systemic quality issues identified through the work of the QIC subcommittees. • Developmental Disabilities Quality Management Plan - Ongoing organizational strategic quality improvement plan that operationalizes the QMS. • Quality Service Review - Review conducted for evaluation of services at individual, provider, and system-wide levels to evaluate: whether individuals' needs are being identified and met through person-centered planning and thinking; whether services are being provided in the most integrated setting appropriate to the individuals' needs and consistent with their informed choice; and whether individuals are having opportunities for integration in all aspects of their lives. QSRs also assess the quality and adequacy of providers' services, quality improvement and risk management strategies, and provide recommendations to providers for improvement.

	• Quorum - Number of voting members required for decision-making. • Regional Quality Councils (RQC) - DBHDS formulated councils, comprised of providers, CSBs, DBHDS quality improvement personnel, and individuals served and their family members that assess relevant data to identify trends and recommend responsive actions for their respective DBHDS designated regions. • State Fiscal Year (SFY) - July 1 to June 30 • Voting Members - Members of the quality committees with the authority to approve meeting minutes, charters, PMIs and other activities requiring approval. • Waiver Management System (WaMS) - The Commonwealth's data management system for individuals on the HCBS DD waivers, waitlist, and service authorizations.