Virginia Department of Behavioral Health & Developmental Services

# DBHDS Quality Service Review

*Aggregate Report*

*Review 5 SFY 2023*

*August 15, 2023*

HSAG HEALTH SERVICES ADVISORY GROUP

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## Appendices

# 1. Executive Summary

The Department of Behavioral Health and Developmental Services (DBHDS) functions as the state authority for the public behavioral health, developmental disabilities, and substance use disorder services system. DBHDS uses Quality Service Reviews (QSRs) and other mechanisms to assess the adequacy of licensed providers' quality improvement strategies and provide technical assistance and other oversight to licensed providers whose quality improvement strategies the Commonwealth determines to be inadequate. The results of the QSR will be used to evaluate:

- The quality of services at an individual, licensed provider, region**,** and system-wide level
- The extent services are provided in the most integrated setting suitable to the individuals' needs and choices
- Whether individuals' needs are being identified and met through person-centered planning and thinking (including building on the individuals' strengths, preferences, and goals)
- Whether services are being provided in the most integrated setting suitable to the individuals' needs and are consistent with their informed choices
- Whether individuals are having opportunities for integration in all aspects of their lives (living arrangements, work, and other day activities, access to community services and activities, and opportunities for relationships with non-paid individuals)

In addition, the QSR process will provide data associated with the following Key Performance Areas (KPAs): *Health, Safety, and Well-Being KPA*, *Community Integration and Inclusion KPA*, and *Provider Capacity and Competency KPA*.

HSAG was selected by DBHDS to evaluate the quality of home and community-based services that are provided through the Home and Community-Based Services Waiver program by conducting QSRs. The QSR includes two components: Provider Quality Reviews (PQRs) and Person-Centered Reviews (PCRs). DBHDS requires all licensed providers and Community Service Boards (CSBs)/Behavioral Health Authorities (BHAs) to participate in the QSR process.

The Round 5 (R5) state fiscal year (SFY) 2023 QSRs were conducted from March 2023 through July 2023, reviewing services that occurred during the lookback period of May 1, 2022, through December 31, 2022. The target sample size approved by DBHDS for this review was 720 individuals. The aggregate findings from the review are summarized within this report.

## Methods for Conducting the Review

The scope of the QSR for SFY 2023 included applicable federal regulations, Virginia Administrative Code, the requirements set forth in the DBHDS Performance Contract, and the Centers for Medicare & Medicaid Services Home and Community Based Services (HCBS) Settings Rule.

The QSR process involved a review of documents such as policies and procedures, QSR quality improvement plans (QIPs) completed by licensed providers/CSBs, licensed provider records, and support coordinator records including any documents used to develop the individual support plan (ISP). The QSR also utilizes data collected through direct observation of and interviews with individuals and staff, interviews with licensed providers/CSBs, interviews with support coordinators, and interviews with individual substitute decision-makers and/or family members.

## Sample Included in QSR

The sample for the QSR review was selected utilizing the DBHDS-approved sampling methodology, based on licensed provider service type. Table 1-1 displays the licensed provider/CSB service type and associated number of PCRs selected for R5.

**Table 1-1: Licensed Provider Service Type and Associated PCRs**

| DD Waiver Service Licensed Provider/CSB Service Type | Population of Service Recipients | Required Sample Size with Finite Population Correction[1] |
|---|---|---|
| Agency Directed Respite | 14 | 13 |
| Community Coaching | 269 | 63 |
| Community Engagement | 2,507 | 79 |
| Group Day | 5,917 | 80 |
| Group Residential Support ≤ 4 Persons | 3,373 | 80 |
| Group residential Support > 4 Persons | 1,924 | 78 |
| Group Home (Customized Rate) | 135 | 51 |
| Independent Living Supports | 152 | 54 |
| In-Home Supports | 2,039 | 79 |
| Sponsored Residential | 2,362 | 79 |
| Supported Living | 179 | 57 |
| Case Management[2] | N/A | 7 |
| **Grand Total** | **18,871** | **720** |

[1]*Service recipients may be duplicated across service types if receiving more than one service type.*

[2]*Case Management was added to include CSBs that only provide case management services to their members. Seven CSBs fell into this group. Because each PCR includes a review of case management services, case management does not require a representative sample of members to participate in PCRs, the total population of members receiving services is not required, and HSAG sampled one member from each of the seven CSBs providing only case management services.*

The sample was distributed among 320 licensed providers/CSBs.

## Sample Attributes

HSAG analyzed the attributes of the individuals selected for the PCR sample. Attributes of the individuals included gender, age, Supports Intensity Scale® (SIS®) level, and the percentage of individuals by Office of Human Rights region.

### *Data Limitations*

PCR results presented in this report may not reflect the full sample set for a given service type. Oversampling was conducted to reduce the potential impact of data limitations on PCR results. Details about oversampling/alternates methodology can be found in the Sampling Guidelines section.

The following were known limitations to the QSRs that could impact data:

- Individuals may have declined to participate
- Individuals may not have been reachable with the contact information provided
- Individuals may have been incarcerated, hospitalized, or deceased
- Individuals may not have received the service during the lookback period
- Licensed providers may not have participated (refusal, non-responsive, closure)

## Evaluation Phase

The evaluation phase consisted of a review of individual care management/support coordination and licensed provider service records. The HSAG review team of experienced QSR reviewers reviewed documentation for the selected cases. Licensed provider service and service coordination documentation were reviewed for an eight-month evaluation window from May 1, 2022–December 31, 2022. The methodology for specific scored elements was designed to incorporate a review of documentation that may have occurred outside of the evaluation window, such as individual support plans that began prior to May 1, 2022. This allowed QSR reviewers to review the information that reflected the services and supports authorized for the individual during the evaluation window, even if the documentation was developed prior to the evaluation period. The review team determined whether each state and federal requirement was supported by evidence of case documentation submitted by the licensed service provider/CSB, as well as the support coordinators involved for each respective case.

## Conclusions

The R5 QSR results demonstrate overall compliance statewide as indicated below:

- A 90 percent or greater compliance for three of nine Individual Service Plan (ISP) Assessment elements
- A 90 percent or greater compliance for 10 of 24 ISP Development and Implementation elements
- A 90 percent or greater compliance for two of 10 Quality Improvement plan elements
- A 90 percent or greater compliance for one of 12 Risk/Harm elements
- A 90 percent or greater compliance for zero of one Incidents element
- A 90 percent or greater compliance for 24 of 30 Provider Capacity and Competency elements
- A 90 percent or greater compliance for three of three Community Integration and Inclusion elements

## Recommendations for Quality Improvement

Of the total number of licensed providers and CSBs who participated in R5 QSR, 257 licensed providers and 39 CSBs received detailed reports noting specific deficiencies and opportunities for improvement that required submissions of QIP responses. Licensed provider/CSB response and/or action was required for any compliance element with a score less than 90 percent. Licensed providers/CSBs submitted QIPs to HSAG for review and approval and the status of implementation of those QIPs will be assessed during the next QSR the licensed provider/CSB is selected to participate in.

Opportunities for improvement statewide can generally be sorted into three areas: individual service planning, service provision, and quality improvement/risk management activities. The purpose of recommendations is to assist licensed providers and/or CSBs to identify and address deficient findings from the QSR and incorporate those findings into QI activities to ensure continuum of care for the individuals served, ensure compliance with all relevant DBHDS regulations and best practices, and improve overall quality of service planning and service provision by licensed providers, CSBs, and statewide. Listed below are QSR compliance elements specific to individual service planning that did not meet the statewide standard for compliance in R5.

The following recommendations are suggested to address deficient QSR findings specific to Individual Service Planning and assist CSBs with incorporation of findings into QI activities. HSAG recommends CSBs:

1. Identify key sources of variability related to deficiencies in ISP development and/or implementation to effectively mitigate those sources of error.
2. Address QSR deficiencies with systemic approaches and interventions, rather than singular actions to address individual findings, to better identify system-wide barriers and patterns within the CSB, including known barriers impacting the statewide system such as staffing shortages.
3. Develop policies and processes to mitigate the potential impact of staffing shortages and/or staffing turnover on CSB capacity to execute best practices for ISP development and implementation, specifically policies that specify how to prioritize case management needs for individuals when staffing shortages impact ability of CSB to maintain timely visits or review of the ISP.
4. Develop policies and processes pertinent to maintaining a continuum of care in the context of staffing shortages and turnover that reflects appropriate and continual assessment of all individuals for changes in status, including those that may require immediate action, with the goal of consistent monitoring for slow decline or changes over time when individual does not have consistent case management supports.

The following recommendations are suggested to address deficient QSR findings specific to service provision by licensed providers and/or CSBs who offer waiver services and assist with incorporation of findings into licensed provider and/or CSB QI activities. HSAG recommends that licensed providers and CSBs who offer waiver services:

1. Identify systemic deficiencies in implementation of HCBS settings rules, across programs, service types, and settings.
2. Ensure policies specific to dignity of risk and individual choice and determination are in place, ensure staff have a working understanding of the concepts represented in each policy, and how they apply to the individuals served by the licensed provider and/or CSB.
3. Develop and implement policies and processes specific to hiring, orienting, and training staff, and policies and/or processes that detail how staff competence is determined and maintained.
4. Continue to incorporate the potential impact of staffing shortages and staff turnover into systemic interventions specific to hiring, training, and maintaining competent staff.

The following recommendations are suggested to address deficient QSR findings specific to licensed provider/CSB QI/RM activities and assist with incorporation of findings into current QI activities. HSAG recommends that licensed providers and CSBs:

1. Utilize QSR findings in tandem with the most current DBHDS tools, resources, and training materials to ensure QI/RM policies, procedures, and processes include all required aspects.
2. Identify key sources of systemic variability related to the inability to proactively identify and address risks of harm for the individuals they serve, such as competency of staff designated and responsible for risk management, turnover of staff responsible for the monitoring of risks for individuals, or other systemic factors, to effectively mitigate those sources of error.
3. Develop policies and processes that require the tracking of community inclusion for individuals served, and incorporate any findings born out of tracking of those activities into QI/RM plans.

The following recommendations are suggested for DBHDS to support licensed providers and/or CSBs in addressing statewide deficiencies in Individual Service Planning, service provision, and/or QI/RM activities, using systemic analysis and interventions. HSAG recommends DBHDS consider the following statewide actions to address findings of R5 of the QSR:

1. Continue to define and communicate best practice expectations to CSBs through development of training curriculum, or utilization of current trainings with this curriculum, for targeted supports specific to:
   a) Identifying, documenting, and addressing changes in status by support coordinators, including how to recognize changes in status that occur over time,
   b) Recognizing when a new assessment requires a change to an in-progress ISP,
   c) Recognizing when a new assessment may be indicated, and/or when intervention or action is most appropriate or required to address the change,

   d) How to properly mitigate and document efforts to mitigate current risks and/or new risks secondary to change in status including when the individual and/or their representative declines referral for assessment or additional supports.
2. Confirm CSB knowledge and understanding of new regulations specific to case management activities, as detailed in 12VAC35-35-112.
3. Confirm QSR tools and compliance elements specific to ISP development and implementation are updated with relevant case management regulations where applicable to better assist CSBs in incorporating DBHDS standards into best practices via future rounds of the QSR.
4. Ensure CSB access to and utilization of the most current DBHDS support coordinator competencies that reflect the most current best practices for ISP development and implementation for CSBs to incorporate into hiring and training activities.
5. Incorporate thresholds in the RAT for identification of cumulative risk(s) that clearly identifies, for staff completing the assessment, when action is required to mitigate those risk factors.
6. Develop and communicate best practice expectations for CSBs pertinent to maintaining a continuum of care in the context of staffing shortages and/or high staff turnover that reflects appropriate and continual assessment of all individuals for changes in status, including those that may require immediate action, with the goal of consistent monitoring for changes to needs or status including slow decline or changes over time.
7. Continue to clarify and communicate expectations for implementation of HCBS settings rule policies and procedures for CSBs, including CSBs that do not provide waiver services outside of case management.
8. Continue to define and communicate best practice expectations, through targeted trainings, with most current DBHDS curriculum for licensed providers and CSBs specific to:
   a) Policies and processes specific to hiring, orienting, and training staff, including assessing staff competence,
   b) Clarify and communicate expectations for completion of advanced competencies by staff that serve individuals in SIS® Level 5 Tier 4,
   c) The development of processes to track community inclusion for the individuals they serve.
9. Identify key sources of provider specific variability related to an inability to proactively identify and address risks, such as the size of the provider, length of time providing services, competency of staff designated as responsible for risk management activities, and/or availability of appropriate local resources to mitigate the complex medical and behavioral risks of individuals statewide.
10. Continue to develop and disseminate trainings with a curriculum that detail key components of QI/RM activities, including new regulations and/or best practices.
11. Provide targeted support to assist licensed providers and CSBs in developing or revising QI/RM programs to ensure the inclusion of key components of QI/RM activities, including findings from QSR pertinent to quality improvement and/or risk management activities.
12. Ensure licensed providers and CSBs understand expectations for full participation in QSR includes observation of staff selected by HSAG to guarantee randomized staff participation and assessment of competency.

# 2. Background and Purpose

The Department of Behavioral Health and Developmental Services (DBHDS) functions as the state authority for the public behavioral health, developmental disabilities, and substance use disorder services system. DBHDS licenses public and private providers of community services throughout Virginia, pursuant to §37.2-405. DBHDS licenses services that provide treatment, training, support, and habilitation to individuals who have behavioral health disorders, developmental disabilities, or substance use disorders; and to individuals receiving services under the Medicaid Home and Community-Based Services Waiver (HCBS Waiver) programs.

HCBS Waiver services support individuals with developmental disabilities to live integrated and engaged lives in their communities. Waiver regulations standardize and simplify access to services, cover services that promote community integration and engagement, promote better outcomes for individuals supported in smaller community settings, and facilitate meeting the Commonwealth's commitments under the community integration mandate of Title II of the Americans with Disabilities Act (ADA), 42 U.S.C. § 12101, as interpreted by Olmstead v. L.C., 527 U.S. 581 (1999).

The Commonwealth uses Quality Service Reviews (QSRs) and other mechanisms to assess the adequacy of licensed providers' quality improvement strategies.

HSAG provides technical and administrative assistance to licensed providers/CSBs whose quality improvement strategies the Commonwealth determines to be inadequate through review and approval of QSR QIPs submitted. The results of the QSR will be used to evaluate:

- The quality of services at an individual, licensed provider, region**,** and system-wide level
- The extent services are provided in the most integrated setting suitable to the individuals' needs and choices
- Whether individuals' needs are being identified and met through person-centered planning and thinking (including building on the individuals' strengths, preferences, and goals)
- Whether services are being provided in the most integrated setting suitable to the individuals' needs and are consistent with their informed choices
- Whether individuals are having opportunities for integration in all aspects of their lives (living arrangements, work, and other day activities, access to community services and activities, and opportunities for relationships with non-paid individuals)

In addition, the QSR process will provide data in one or more of the following areas:

- Safety and freedom from harm (e.g., neglect and abuse, injuries, use of seclusion or restraints, deaths, the effectiveness of corrective actions, licensing violations)
- Physical, mental, and behavioral health and well-being (e.g., access to medical care, including preventative care; timeliness and adequacy of interventions, particularly in response to changes in status)

- Avoiding crises (e.g., use of crisis services, admissions to emergency rooms or hospitals, admissions to training centers or other congregate settings, contact with the criminal justice system)
- Stability (e.g., maintenance of chosen living arrangement, change in licensed providers, work/other day program stability)
- Choice and self-determination (e.g., service plans developed through a person-centered planning process, choice of services and licensed providers, individualized goals, self-direction of services)
- Community inclusion (e.g., community activities, integrated work opportunities, integrated living options, educational opportunities, relationships with non-paid individuals)
- Access to services (e.g., waitlists, outreach efforts, identified barriers, service gaps, and delays, adaptive equipment, transportation, availability of services geographically, cultural, and linguistic competency)
- Licensed provider capacity (e.g., caseloads, training, staff turnover, licensed provider competency)
- Licensed provider implementation of approved QSR QIP

These areas are captured in three DBHDS Key Performance Areas (KPAs): *Health, Safety, and Well-Being KPA*, *Community Integration and Inclusion KPA*, and *Provider Capacity and Competency KPA*.

HSAG was selected by DBHDS to evaluate the quality of home and community-based services that are provided through the HCBS Waiver program by conducting QSRs. The QSR includes two components: Provider Quality Reviews (PQRs) and Person-Centered Reviews (PCRs). DBHDS requires all licensed providers and Community Service Boards (CSBs)/Behavioral Health Authorities (BHAs) [hereafter referred to as CSBs] to participate in the QSR process.

The Round 5 (R5) QSRs were conducted between March 2023 and July 2023, with in-person observations and interviews conducted from May 2023 through June 2023. The QSR review included licensed providers not selected for review in Round 4 (R4) and those providers who did not participate in R4, plus the remaining 50% of CSBs not selected for a PQR review in R4. Due to the nature of the QSR process, CSBs not selected for review of a waiver service in R5 (n=19) were required to provide documentation related to support coordination for individuals sampled for the Person-Centered Review of a licensed provider/CSB and participate in the submission of required Quality Improvement Plans (QIPs) to HSAG, if applicable. The aggregate findings from the R5 state fiscal year (SFY) 2023 review are summarized within this report.

## Methods for Conducting the Review

The scope of the QSR for SFY 2023 included applicable federal regulations, Virginia Administrative Code, the requirements set forth in the DBHDS Performance Contract, and the HCBS Settings Rule. HSAG developed a QSR File Review Tool in collaboration with DBHDS, which was used to record the findings of the review at the licensed provider/CSB and the individual level. The electronic QSR review tools addressed the services and support necessary to meet the individuals' needs. The tools included elements for review of records and individual service plans to ensure that they met the intent of the HCBS Settings Final Rule, such as a person-centered approach to service planning and service delivery, and community integration. The QSR electronic tools included indicators to review for the inclusion, facilitation, and receipt of HCBS services and supports. QSR reviewers verified whether ordered and clinical care assessments were documented in the records and the individual support plans (ISP) reviewed for the QSR. In scenarios where there are clinical concerns that are not documented in the service plan, the reviewers utilized the Clinical Decision Tree and referred to the clinical reviewer. All review elements of the QSR were recorded in the electronic QSR tools.

The QSR process included a review of documents such as policies and procedures, QSR quality improvement plans (QIPs) completed by licensed providers/CSBs, licensed provider records, and support coordinator records including any documents used to develop the individual support plan (ISP). The QSR also utilizes data collected through direct observation of and interviews with individuals and staff, interviews with licensed providers/CSBs, interviews with support coordinators, and interviews with individual substitute decision-makers and/or family members.

## Sampling Guidelines

Using QSR sampling strategy considerations provided by DBHDS, HSAG developed a sampling methodology inclusive of a representative sample of individuals for each Developmental Disabilities (DD) Waiver service provided to its members, such that estimates of proportions may be calculated within a 10.88 percent margin of error (MOE). The PCR sample did not need to be representative of the populations served by each licensed provider or by region of the state. Some individuals selected for PCRs declined the opportunity to participate, expired prior to the completion of the PCR interview, or may have been excluded due to not meeting other eligibility criteria. An oversample of DD Waiver service recipients, that was up to 100 percent of the required sample size, was drawn to provide replacements when individuals could not or chose not to participate. Some members receiving these DD Waiver services who declined or were otherwise unable to participate may not have been able to be replaced by others receiving those services. For DD Waiver services where nearly the entire population was included in the sample, a limited oversample was drawn. If the refusal rate for participation by recipients of those services was high enough, it was possible that the oversample may not have been large enough to obtain the necessary sample size and HSAG then proceeded to collect PCR data through record and document reviews only.

During R5, HSAG conducted a PQR review of 100 percent of eligible licensed providers not reviewed in R4 and 50 percent of CSBs delivering services during the look back period. Therefore, R5 consists of

320 PQRs of licensed providers and CSBs. The target sample size approved by DBHDS for this review was 720 individuals. Based on the target sample size, it was not possible to sample at least one PCR from each licensed provider (due to reasons stated above in the *Data Limitations* section), therefore, some licensed providers do not have any associated PCRs in the sample.

## Sample Included in QSR

The sample for the QSR review was selected utilizing the DBHDS-approved sampling methodology, based on licensed provider/CSB service type. Table 2-1 displays the licensed provider/CSB service type and associated number of PCRs selected for R5.

**Table 2-1: Licensed Provider/CSB Service Type and Associated PCRs**

| DD Waiver Service Licensed Provider/CSB Service Type | Population of Service Recipients | Required Sample Size with Finite Population Correction[1] |
|---|---|---|
| Agency Directed Respite | 14 | 13 |
| Community Coaching | 269 | 63 |
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| **Grand Total[1]** | **18,871** | **720** |

[1]*Service recipients may be duplicated across service types if receiving more than one service type.*

[2]*Case Management was added to include CSBs that only provide case management services to their members. Seven CSBs fell into this group. Because each PCR includes a review of case management services, case management does not require a representative sample of members to participate in PCRs, the total population of members receiving services is not required, and HSAG sampled one member from each of the seven CSBs providing only case management services.*

The sample was distributed among 320 licensed providers/CSBs.

## Sample Attributes

Figures 1, 2, 3, 4, and 5 provide information on the attributes of the individuals in the R5 sample. The PCR sample is representative of the DD Waiver services provided in the state. Figures below include demographic data for all individuals who met the eligibility criteria, to be included in QSR, (n=712). Eight individuals were excluded from the total sample due to death and the lack of availability of an alternate.

Figure 2-1 displays the distribution of individuals by gender.

**Figure 2-1: Percentage of Gender**

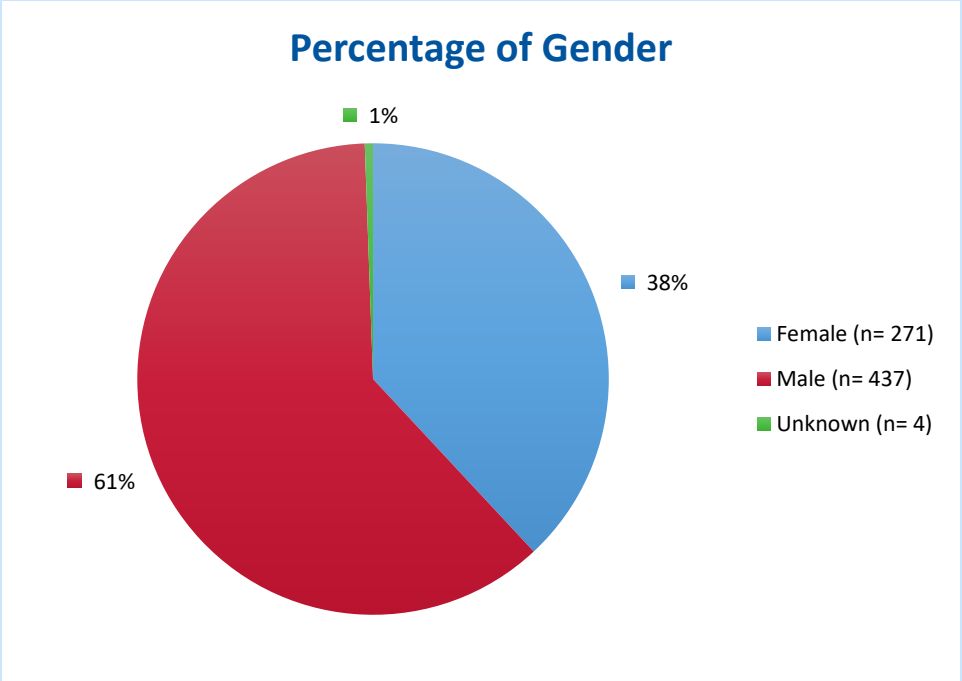


Figure 2-2 displays the distribution of individuals by age group.

**Figure 2-2: Distribution of Individuals by Age**

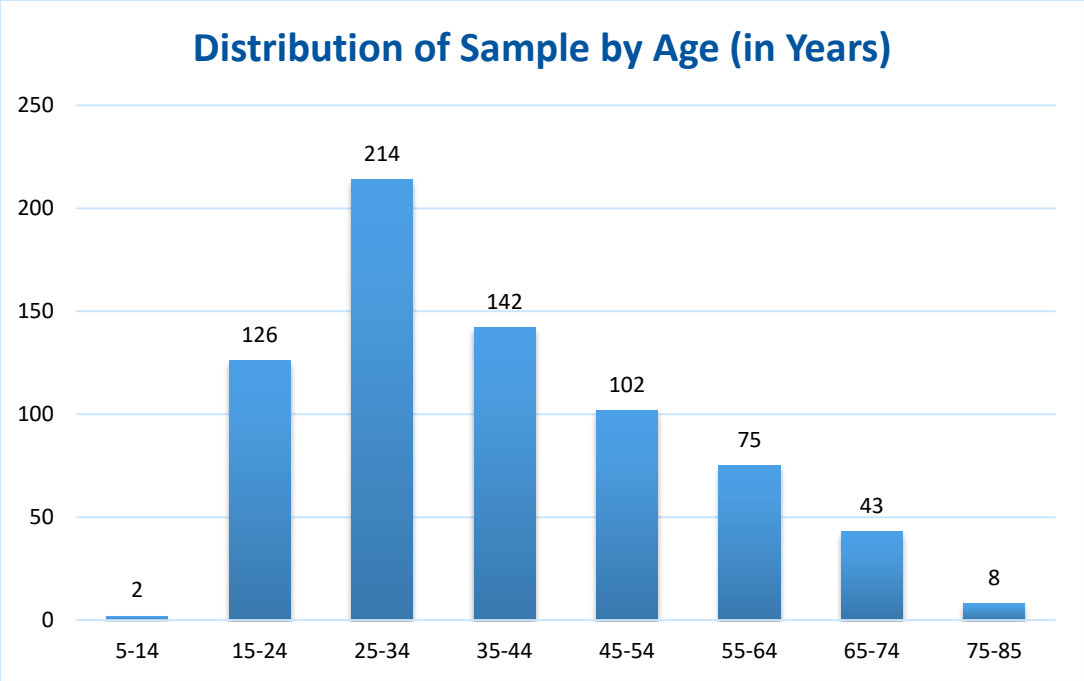
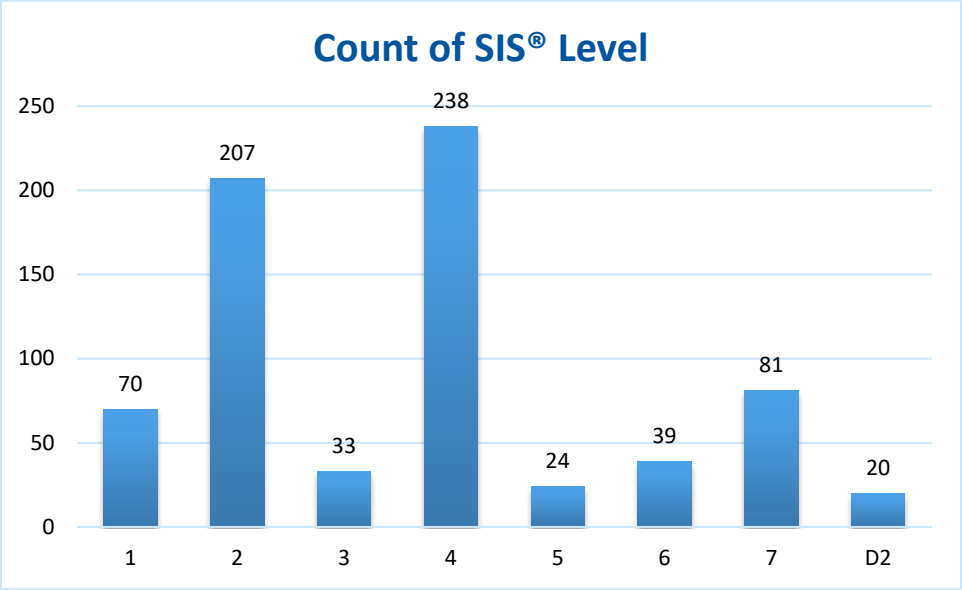


Figure 2-3 displays the distribution of the Supports Intensity Scale® (SIS®) levels of the individuals selected for the sample. The SIS® is an assessment instrument utilized by DBHDS that assesses the level of support an individual needs, as well as what is important to and for him/her. The SIS® level numbering refers to the level of intensity of support needs of the individual, with level 1 representing mild support needs and higher levels such as 6 and 7 representing intensive medical and behavioral support needs. The D2 level describes individuals who have been assigned a default level 2 and have not yet received a SIS® assessment; these individuals receive a final level after completion of the SIS®.

**Figure 2-3: SIS® Level**



QSR results are presented by region. Figure 2-4 displays the DBHDS regions. Figure 2-5 displays the distribution of the individuals in the sample by region of the state.

**Figure 2-4: DBHDS Regions**

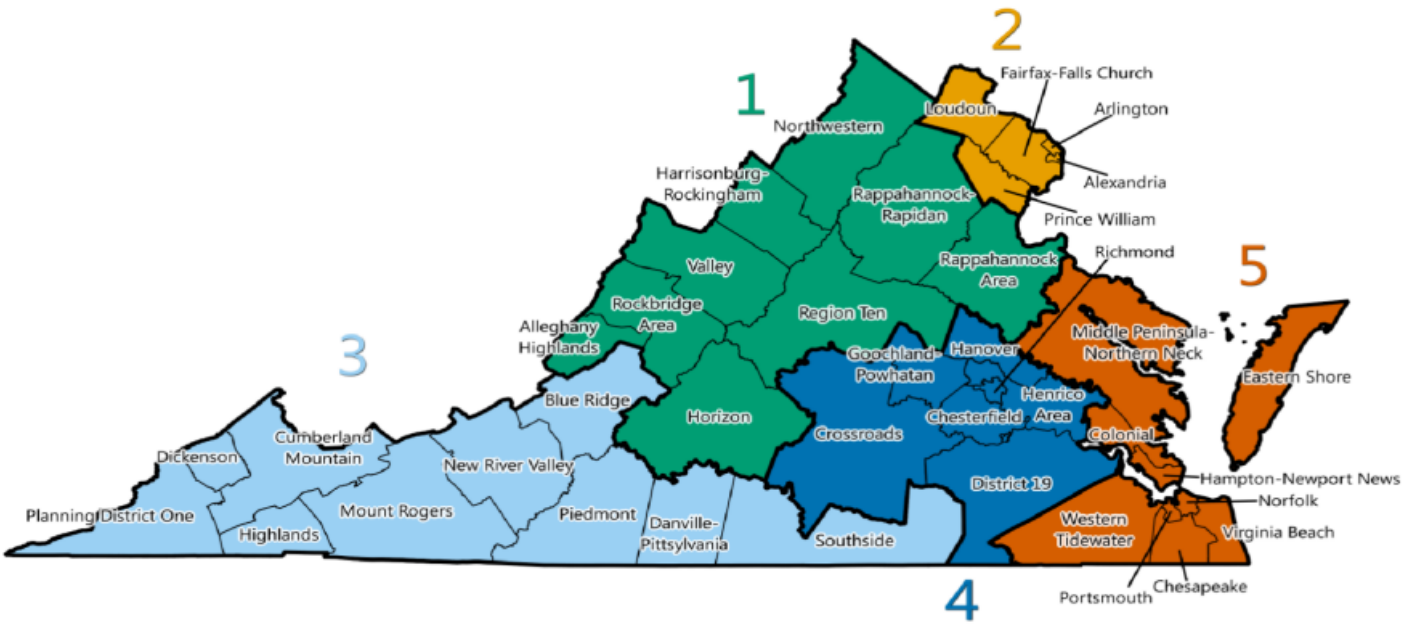
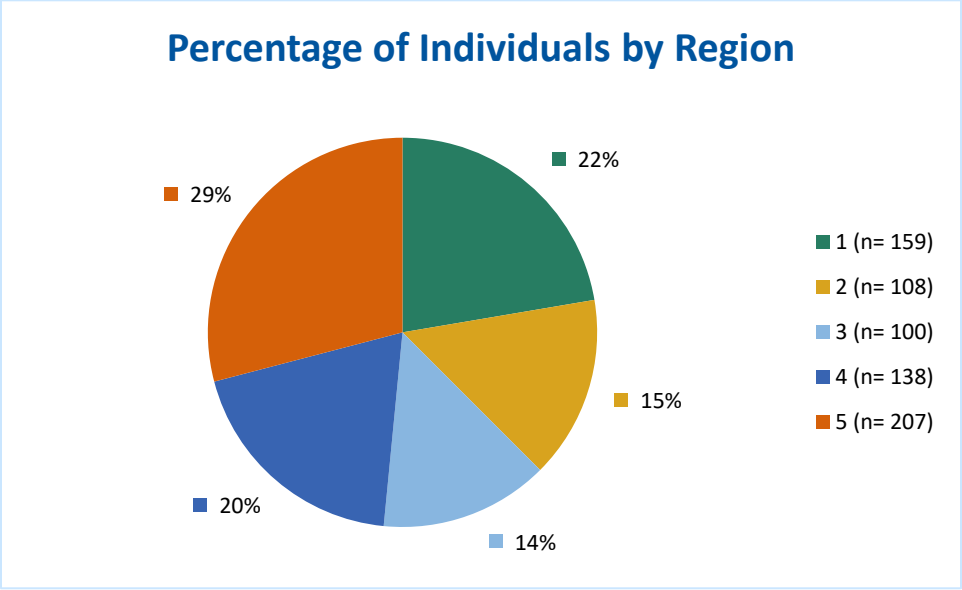



**Figure 2-5: Percentage by Region**



### *Data Limitations*

Individuals sampled for the QSR are not required to participate, hence the original sample for a given licensed provider or licensed provider service type may change due to individual choice, or one of the reasons noted below. Oversampling, or alternate selection, was conducted to reduce the potential impact of these data limitations on PCR results.

The following were known limitations to the QSRs that could impact data:

- Individuals may have declined to participate
- Individuals may not have been reachable with the contact information provided
- Individuals may have been incarcerated, hospitalized, or deceased
- Individuals may not have received the service during the lookback period
- Licensed providers may not have participated (refusal, non-responsive, closure)

## Evaluation Phase

The evaluation phase consisted of a review of individual care management/support coordination and licensed provider service records. The HSAG review team of experienced QSR reviewers reviewed documentation for the selected cases. Licensed provider service and service coordination documentation were reviewed for an eight-month evaluation window from May 1, 2022–December 31, 2022. The methodology for specific scored elements was designed to incorporate the review of documentation that may have occurred outside of the evaluation window, such as individual support plans that began prior to May 1, 2022. This allowed QSR reviewers to examine information that reflected the services and supports authorized for the individual during the evaluation window, even if the documentation was developed prior to the evaluation period. The review team determined whether each state and federal requirement was supported by evidence of case documentation submitted by the licensed service provider, as well as the support coordinators involved for each respective case.

## Data Analysis and Aggregation

HSAG aggregated the review results across all licensed provider service types and individuals included in the sample for the licensed provider/CSB. Each applicable requirement within each domain was scored as *Yes, No, N/A (Not Applicable), or UTA (Unable to Assess)*. HSAG calculated an overall percentage-of-performance score for each of the requirements. HSAG calculated the score for each requirement by adding the score from each case, indicating either a score of *Yes* (value: 1 point) or *No* (value: 0 points) and dividing the summed scores by the total number of applicable cases. Data analysis also included an aggregate performance by a licensed provider/CSB.

## Scoring Methodology

To quantify the compliance performance for the scored elements, HSAG used a two-point scoring methodology. Each requirement was scored as *Yes* or *No* according to the criteria identified below.

***Yes*** indicated that the licensed provider/CSB achieved the following criteria:

- Documentation in the cases reviewed met the evaluation criteria assigned to each requirement

***No*** indicated either of the following:

- Not all documentation was present
- Documentation in the cases reviewed did not meet the evaluation criteria assigned to each requirement

***N/A and UTA*** indicated a requirement that was not scored for performance based on the criteria listed for the specific element in the PQR and/or PCR tool.

The data collected for this report were obtained from a limited, but representative, sample of individuals, meaning the results presented are an accurate representation of the average experiences of the individuals within that service type. Additionally, licensed providers/CSBs were assessed using qualitative elements that informed the QSR review which are not presented in this report.

## Performance Areas and KPAs

HSAG aggregated QSR results related to the following areas of person-centered planning and service provision:

- ISP Assessment
- ISP Development and Implementation
- Quality Improvement Plan
- Risk/Harm
- Incidents
- Provider Capacity and Competency
- Community Integration and Inclusion
- Individual and SDM/Family member interview responses

Compliance elements for these areas were associated with the KPAs: *Health, Safety, and Well-Being; Community Integration and Inclusion;* and *Provider Capacity and Competency.* All R5 PQR and PCR elements applicable to each KPA are listed below, with R5 statewide compliance score noted in parentheses for each element. Detailed scoring criteria for each compliance element listed below can be found in QSR Results Section 3.

The QSR process included a review of documents, such as policies and procedures, licensed provider status of implementation of HSAG approved quality improvement plans (QIPs), licensed provider records, support coordinator records including the individual support plan (ISP), interviews and observations of individuals, and interviews with licensed providers, support coordinators, and individual family members and/or substitute decision-makers.

### *Health, Safety, and Well-Being KPA*

HSAG reviewer assessment of the *Health, Safety, and Well-Being KPA* compliance elements, in R5, yielded the following results:

- The licensed provider/CSB had someone designated as responsible for risk management functions with evidence of completion of department approved training attestation (90%)
- The licensed provider/CSB had a risk management plan (84%)
- The licensed provider/CSB conducted systemic review of risk management plan annually and a review of serious incidents quarterly (78%)
- The licensed provider/CSBs risk management plan was thorough (71%)
- The licensed provider/CSB implements risk management processes, including the establishment of uniform risk triggers and thresholds, that enabled them to adequately address harms and risks of harm (83%)

- The licensed provider/CSB had a QI Program Policy/Procedure (59%)
- The licensed provider/CSB had a quality improvement plan (92%)
- The licensed provider/CSB quality improvement plan was thorough (53%)
- The licensed provider/CSB quality improvement plan was complete (72%)
- The licensed provider/CSBs quality improvement plan was reviewed annually (76%)
- Licensed providers/CSBs had active risk management and quality improvement programs (74%)
- Licensed providers and CSBs who offer waiver services had policies and procedures that address Home and Community-Based Services (HCBS) rights (93%)
- Licensed providers and CSBs who offer waiver services were able demonstrate the HCBS policies and procedures have been reviewed with individuals being served (88%)
- The licensed provider/CSB had a policy and procedure that demonstrates assurance of individual choice and self-determination (76%)
- The licensed provider/CSB had policies that address the dignity of risk (69%) and medical and behavioral health emergencies (81%)
- The licensed residential provider had policies that support individuals' participation in financial management and decision making (71%)
- The licensed residential provider had lease, residency agreement, or other written agreement in place which includes language referencing individual protections from eviction. (75%)
- The CHRIS incident report spreadsheet was free from licensed provider/CSB patterns of abuse, neglect, or exploitation (89%)
- The licensed provider/CSB made progress on actions identified in QSR QIP (64%)
- The licensed provider/CSB documentation review indicated the completion of an annual physical exam (76%)
- The licensed provider/CSB documentation reviewed indicated the completion of an annual dental exam (61%)
- The licensed provider and CSBs who offer waiver services documentation reviewed indicated receipt and signature of HCBS rights disclosure for individuals on an annual basis (80%)
- The licensed provider/CSB documentation reviewed indicated modifications for health and safety risks have been approved as appropriate or show evidence of approval requests in process (53%)
- The CSB developed an ISP within 365 days of the previous ISP (99%)
- The ISP developed by CSB included all medical needs identified in the Supports Intensity Scale® (SIS®) or other assessment utilized to develop the ISP (72%)
- The ISP developed by CSB included all behavioral needs identified in the Supports Intensity Scale® (SIS®) or other assessment utilized to develop the ISP (69%)
- The CSB completed the Risk Assessment Tool (RAT) timely (84%)
- The ISP developed by the CSB incorporated high-risk health factors from the RAT (61%)

- The annual assessment completed by the CSB included all information related to the person's ISP (66%)
- A review of the individual's record or conversations with Support Coordinator identified the need for additional assessments (37%) for one or more of the following medical and/or behavioral conditions observed by the QSR reviewer while onsite:
  - For individuals with limited mobility or who are at high risk of pressure injury; the individual is experiencing new loss of feeling in limbs or new symptoms of edema that would indicate physical therapy assessment.
  - For individuals who are prescribed medications; the individual is experiencing side effects that should be evaluated by a physician.
  - For individuals with a history of mental health conditions (as indicated in Part II of the ISP: Physical and Health Conditions section); the individual would benefit from a referral to a psychiatrist.
  - For individuals with behavior or crisis supports (as indicated in Part II of the ISP: Behavioral and Crisis Supports section); the individual would benefit from referral to therapeutic consultation or re-evaluation of current behavioral supports.
  - For individuals with complex medical needs (tracheostomy, gastrostomy tube, ventilator); the individual would benefit from re-evaluation of current nursing services.
  - For individuals with special diet or nutritional needs (as indicated in Part II of the ISP: Physical and Health Conditions section); the individual would benefit from a nutritional assessment, swallow study, or occupational treatment assessment.
  - For individuals who have needs requiring support for communication or language, or for whom a professional evaluation related to adaptive equipment would be beneficial (as indicated in Part II of the ISP: Communication and Assistive Technology and Modifications section); the individual or family has an interest in a communication device.
- The ISP Part I developed by the CSB was complete and thorough (81%)
- The ISP Part II developed by the CSB included the individual's health and behavioral support needs (70%), physical and health conditions (78%), and social and developmental behavioral family history (90%)
- The ISP Part II developed by the CSB included medications (96%)
- The ISP developed by the CSB included strategies for solving conflict or disagreement that occurs during the ISP meeting regarding ISP supports, outcomes, or individual decisions (85%)
- All needs identified in Part II of the ISP developed by the CSB were addressed under an outcome in Part III including the responsible provider (83%)
- The CSB completed a review of the ISP with the individual every 90 days and/or quarterly as required (73%)
- Assessment(s) were completed by the CSB after the initiation of the ISP plan and used to inform changes to the ISP as appropriate (48%)
- The ISP developed by the CSB and/or the individual's file included documentation the support coordinator (SC) identified and resolved any unidentified or inadequately addressed risk, injury,

need, or change in status, a deficiency in the individual's support plan or its implementation, or a discrepancy between the implementation of supports and services and the individual's strengths and preferences (20%)

- The ISP developed by the CSB was developed according to the processes required (31%)
- The ISP developed by the CSB indicated outcomes have been developed as appropriate for the following life area(s): safety & security (90%) and health living (95%)
- Licensed provider and CSB staff knew what medications the individual is taking (97%) and the common side effects of the medication (94%), or where to locate that information, if applicable.
- The individual's/licensed provider's/CSBs environment were neat and clean (96%)
- The person's/licensed provider's/CSBs environment were accessible (99%)

## *Community Integration and Inclusion KPA*

HSAG reviewer assessment of the *Community Integration and Inclusion KPA* compliance elements, in R5, yielded the following results:

- The licensed provider/CSB was able to demonstrate methods or strategies to promote participation in meaningful work activities as determined by the individual (93%)
- The licensed provider/CSB was able to demonstrate methods or strategies to promote participation in non-large group activities as determined by the individual (96%)
- The licensed provider/CSB was able to demonstrate methods or strategies to encourage participation in community outings with people other than those with whom they live including community members (96%)
- The ISP Part II developed by the CSB included individual's communication, assistive technology, and modification needs (91%)
- The ISP Part II developed by the CSB included the individual's employment status and assessment of barriers to employment (97%)
- The ISP Part II developed by the CSB included the individual's meaningful day and community involvement status (98%)
- The individual had support from licensed providers, CSBs, and family members during the development of the ISP that they wanted (97%)
- The ISP developed by the CSB indicated outcomes had been developed as appropriate for the following life area(s): employment (81%), integrated community involvement (93%), community living (96%), social & spirituality (84%), citizenship & advocacy (95%)
- All needs in ISP Part II developed by the CSB were assigned to Part III Outcome, including responsible provider (83%)
- All outcomes identified in ISP Part III developed by the CSB were linked to Part V Plan for Supports (PFS) as appropriate (89%)

- The ISP developed by the CSB and/or other documentation supported that the individual was given a choice regarding services and supports, including the individual's residential setting, and who provides them (88%)
- The ISP developed by the CSB included signatures of the individual (or representative) and all licensed providers responsible for its implementation (93%)
- Licensed provider and CSB staff engaged with the individual based on the person's preference and interest (98%)
- The individual was being offered choices by licensed providers and CSB staff throughout the visit (98%)

## *Provider Capacity and Competency KPA*

HSAG reviewer assessment of the *Provider Capacity and Competency KPA* compliance elements, in R5, yielded the following results:

- The licensed provider/CSB had a hiring policy and procedure (79%)
- The licensed provider/CSB hiring policy included requirements for background checks (91%)
- The licensed provider/CSB had an orientation training policy for all staff at all levels (79%)
- The licensed provider/CSB had a written process for determining staff competence (70%)
- Licensed provider/CSB Employee records submitted included proof of background checks (95%)
- Licensed provider/CSB employee records submitted included documentation of provider-based orientation training (94%)
- Licensed provider/CSB employee records submitted included proof of competency-based training (91%)
- Licensed provider/CSB employee records submitted included documentation of advanced competency training as appropriate (84%)
- The licensed provider had evidence supporting implementation of annual HCBS-specific training with all staff (79%)
- The licensed provider/CSB staff service provided to the individual reflects the implementation of the ISP Part V as written (98%)
- The licensed provider/CSB staff utilized strategies identified in the behavioral support plan to support the individual, if applicable (100%)
- The licensed provider/CSB staff utilized medical and behavioral protocols to support the individual as outlined in the plan (99%)
- The licensed provider/CSB staff demonstrated competency in supporting the individual (100%)
- The licensed provider/CSB staff utilized adaptive equipment the individual had as part of their plan (94%)

- The licensed provider/CSB staff were able to describe things important to and important for the individual (98%)
- The licensed provider/CSB staff were able to describe the outcomes worked on in this environment (97%)
- The licensed provider/CSB staff were able to describe the medical support needs (95%) and behavioral support needs (97%) of the individual
- The licensed provider/CSB staff were familiar with the medical (95%) and/or behavioral support needs (95%) of the individual and any signs/symptoms that need to be monitored

# 3. QSR Results

## Results

The R5 QSR results are aggregated statewide, by region, by CSB, and by licensed provider service type. The data collected are representative at the state level by service category only, as described in the methodology section of this report. Licensed provider service type results are weighted and reported to the tenth of a percent to reflect statistical representativeness and represent the aggregate performance of the licensed provider service types identified in the methodology section of this report.

Data in the tables below reflect the aggregated results, which are representative of the statewide compliance threshold for each element. Each compliance element listed in tables below was scored as Yes, No, N/A (Not Applicable), or UTA (Unable to Assess). HSAG calculated an overall percentage-of-performance score for each of the requirements using Yes/(Yes+No).

Region, CSB, and licensed provider service type-specific results are available in Appendices A–AN. Region-specific results represent aggregate results across all five statewide regions, CSB-specific results represent aggregate results across all CSBs, and licensed provider service type-specific results represent performance scores across all licensed providers in those service types.

The target compliance threshold for R5 reviews was 90 percent. HSAG reported results performing at, above, and below 90 percent compliance to identify potential opportunities for improvement.

### *ISP Assessment Compliance Elements*

Below are the results for nine compliance elements that best represent the core components of ISP Assessment. Table 3-1 provides the performance results for the ISP assessment elements.

**Table 3-1: ISP Assessment Compliance Elements**

| Compliance Element | Aggregate Type | Result |
|---|---|---|
| Were any assessments completed after the initiation of the ISP and used to inform changes to the ISP? | Statewide | 48% |
| Does the ISP incorporate high-risk health factors identified in the RAT? | Statewide | 61% |
| Is Part I of the ISP complete and thorough? | Statewide | 81% |
| Does the assessment include all information related to the person's ISP? | Statewide | 66% |
| Does the ISP Part II include the individual's health and behavioral support needs? | Statewide | 70% |
| Does the ISP Part II include medications? | Statewide | 96% |
| Does the ISP Part II include the individual's physical and health conditions? | Statewide | 78% |

| Compliance Element | Aggregate Type | Result |
|---|---|---|
| Does the ISP Part II include the individual's social, developmental, behavioral, and family history? | Statewide | 90% |
| Does the ISP Part II include the individual's communication, assistive technology, and modifications needs? | Statewide | 91% |

As described in Table 3-1, statewide results revealed a performance of 90 percent or greater compliance for three of the nine elements.

Enhancement opportunities for CSBs include ensuring:

- ISP update, when assessments completed after the ISP start date indicate a change to the ISP is needed.
- Incorporation of high-risk health factors, identified in the RAT, into the ISP.
- ISP Part I contains adequate information to have a good idea of the individual's specific likes, preferences, and how the person is best supported (i.e., complete and thorough).
- The annual assessment, completed in conjunction with ISP development, included taking the individual's history, identifying the individual's needs including known and potential risks, and gathering information from other relevant sources.
- ISP, Part II, includes the individual's physical and health conditions.
- ISP, Part II, includes the individual's health and behavioral support needs.

CSB, region, and service type-specific results are available in Appendix A-B, Appendix J, and Appendix V-W, respectively.

## *ISP Development and Implementation Compliance Elements*

Below are the results for 2 compliance elements that represent core components of ISP Development and Implementation. Table 3-2 provides the performance results for the ISP development and implementation elements.

**Table 3-2: ISP Development and Implementation Compliance Elements**

| Compliance Element | Aggregate Type | Result |
|---|---|---|
| The ISP for this review period is within 365 days of the previous ISP. | Statewide | 99% |
| The ISP reviewed identified all medical needs found in the SIS® or other relevant assessments. | Statewide | 72% |
| The ISP reviewed identified all behavioral needs found in the SIS® or other relevant assessments. | Statewide | 69% |
| Was the RAT completed timely? | Statewide | 84% |
| Are any additional assessments needed for conditions listed?[1] | Statewide | 37% |

| Compliance Element | Aggregate Type | Result |
|---|---|---|
| Does the ISP Part II include the individual's employment status and assessment of barriers to employment? | Statewide | 97% |
| Does the ISP Part II include the individual's meaningful day and community involvement status? | Statewide | 98% |
| Did the individual have support from people during the development of the ISP that they wanted? | Statewide | 97% |
| Are all risks identified in Part II of the ISP addressed under an outcome in Part III? | Statewide | 73% |
| Outcomes are developed in the life area of Employment as appropriate. | Statewide | 81% |
| Outcomes are developed in the life area of Integrated Community Involvement as appropriate. | Statewide | 93% |
| Outcomes are developed in the life area of Community Living as appropriate. | Statewide | 96% |
| Outcomes are developed in the life area of Safety & Security as appropriate. | Statewide | 90% |
| Outcomes are developed in the life area of Healthy Living as appropriate. | Statewide | 95% |
| Outcomes are developed in the life area of Social & Spirituality as appropriate. | Statewide | 84% |
| Outcomes are developed in the life area of Citizenship & Advocacy as appropriate. | Statewide | 95% |
| Are all needs in Part II assigned to Part III Outcome, including the responsible provider? | Statewide | 83% |
| Are all outcomes identified in Part III linked to Part V PFS as appropriate? | Statewide | 89% |
| Does the ISP include strategies for solving conflict or disagreement that occurs during the ISP meeting regarding ISP supports, outcomes, or individual decisions? | Statewide | 85% |
| The ISP and/or other SC documentation confirmed a review of the ISP was conducted with the individual quarterly or every 90 days. | Statewide | 73% |
| The ISP and/or other documentation supports that the individual was given a choice regarding services and supports, including the individual's residential setting, and who provides them. | Statewide | 88% |
| The ISP includes the signatures of the individual (or representative) and all providers responsible for its implementation. | Statewide | 93% |
| The ISP and/or the individual's file included documentation the support coordinator identified and resolved any unidentified or inadequately addressed risk, injury, need, or change in status, a deficiency in the individual's support plan or its implementation, or a discrepancy between the implementation of supports and services and the individual's strengths and preferences. | Statewide | 20% |
| The ISP was developed according to the processes required. | Statewide | 31% |

[1]*This compliance element was measured using scoring criteria that is inverse, meaning a lower percentage indicates better compliance. Compliance cut-off standards remained the same, hence compliance percentages greater than 10% indicate areas with opportunities for improvement. For a list of the referenced conditions, please see page 2-19 above.*

As described in Table 3-2, statewide results revealed a performance of 90 percent or greater compliance for ten of the 24 elements.

Enhancement opportunities for CSBs include ensuring:

- ISP identification of medical needs and/or behavioral needs found in the SIS® or other relevant assessment.
- Timely completion of the RAT.
- Establishment of protocols/procedures for documenting the need for and completion of assessments, when an individual's medical or behavioral health condition changes and for determining when a re-evaluation of the individual's condition, existing support services, or adaptive equipment should occur. Specifically, under the conditions list on page 2-19 above.
- Inclusion of all risks identified in Part II, of the ISP, are addressed under an outcome in Part III of the ISP.
- Inclusion of all needs identified in Part II, of the ISP, are assigned to an ISP Part III outcome and a responsible provider.
- Inclusion of all outcomes identified in Part III, of the ISP, are linked to the ISP Part V Plan for Supports as appropriate.
- Inclusion of outcomes in life areas of Employment, and Social & Spirituality in Part III of the ISP, as appropriate.
- ISP or other record documentation that supports individual choice regarding services and supports, including an individual's residential setting, and who provides these services, including documentation of: 1) education materials being presented in an accommodating format for the individual and/or authorized representative or family; 2) annual education being provided about less restrictive community options to any individuals living outside their own home or family's home, or non-disability specific settings and an option for a private unit in a residential setting; and 3) the Virginia Informed Choice form being present.
- ISP documentation of strategies used to resolve conflict that may arise during ISP planning.
- ISP and other SC documentation confirmed that the ISP was reviewed with individuals quarterly or every 90 days.
- ISP and/or other documentation supports that the individual was given a choice regarding services and supports, including the individual's residential setting, and who provides them.
- ISP documentation that the SC identified and resolved any unidentified or inadequately addressed risk, injury, need, or change in status; a deficiency in the individual's support plan or its implementation; or a discrepancy between the implementation of supports and services and the individual's strengths and preferences.
- ISP was developed according to processes required including coordination with the individual and their family/caregiver, as appropriate, all providers, and others as desired by the individual, completion of updated VIDES, completed within a year of previous VIDES; and completion of updated RAT.

CSB, region, and service type-specific results are available in Appendices C-H, Appendices K-P, and Appendices X-AC, respectively.

## Quality Improvement Plan Compliance Elements

Below are the results for ten compliance elements that represent the core components of Quality Improvement Plans. Table 3-3 provides the performance results for the Quality Improvement Plan elements.

**Table 3-3: Quality Improvement Plan Compliance Elements**

| Compliance Element | Aggregate Type | Result |
|---|---|---|
| Does the agency have a QI program policy and procedure? | Statewide | 59% |
| Does the agency have a QI plan? | Statewide | 92% |
| Is the QI plan thorough? | Statewide | 53% |
| Is the QI plan complete? | Statewide | 72% |
| The quality improvement plan is reviewed annually. | Statewide | 76% |
| Providers have active risk management and quality improvement programs. | Statewide | 74% |
| Does the agency have policies and procedures that address HCBS rights? | Statewide | 93% |
| Are those (HCBS) policies and procedures reviewed with the individuals being served? | Statewide | 88% |
| Does the agency have policies around the assurance of individual choice and self-determination? | Statewide | 76% |
| Does the agency have policies around the dignity of risk? | Statewide | 69% |

As described in Table 3-3, statewide results revealed a performance of 90 percent or greater compliance for two of the 10 elements.

Enhancement opportunities for licensed providers and/or CSBs include ensuring:

- Licensed provider/CSB development of QI program policy and procedure distinct from the provider's QI plan, that explains when to use various quality improvement tools and processes; includes measurable goals and objectives, includes an update of the licensed provider/CSBs QI plan, includes of the submission of corrective action plans to the department for approval or continual implementation of the corrective action plan with additional measures to prevent the recurrence of the cited violation and address identified systemic deficiencies pursuant to 12VAC35-105-170, and including how providers track community inclusion for individuals receiving services; specifically, how the provider determines if its personnel promote meaningful work and participation in non-large group activities, and how personnel encourage participation in community outings with people other than those with whom they live.
- Licensed provider/CSB development of QI plan that is thorough; including all aspects of 12VAC35-105-620 A-E, specifically that the QI Plan:
    - Be reviewed and updated at least annually, when the provider is issued a licensing citation or CAP, or there is a change in systems or programs;

  - Define measurable goals and objectives;
  - Include and report on statewide performance measures, as required by DBHDS;
  - Monitor implementation and effectiveness of approved corrective action plans pursuant to 12VAC35-105-170;
  - Include ongoing monitoring and evaluation of progress toward meeting established goals and objectives;
  - Detail how the provider plans to and/or is addressing any findings born out of the execution of tracking community inclusion for individuals served.
- Licensed provider/CSB development of QI plan that is complete, specifically including the following elements:
  - Design and scope;
  - Governance and leadership;
  - Feedback/data systems and monitoring;
  - Performance improvement projects;
  - Systemic analysis;
  - Systemic actions;
  - Include input from individuals receiving services and their authorized representatives, if applicable, about services used and satisfaction level of participation in the direction of service planning.
- Licensed provider/CSB documentation of annual review of QI plans.
- Licensed provider/CSB maintains an active quality improvement and risk management program as evidenced by provider staff engagement in QI and/or risk efforts.
- Licensed provider/CSB review of HCBS policies with individuals they serve when applicable
- Licensed provider/CSB development of policies around the assurance of individual choice and self-determination.
- Licensed provider/CSB development of policies around the dignity of risk.

Provider service type level tabulation of the provider PQR compliance results was not possible due to the measurement of compliance by the provider rather than their specific service type. For example, a single provider PQR compliance score could be attributed to more than one service type, resulting in the provider's PQR compliance score being included in the aggregate score for more than one service type. Region level tabulation of provider PQR compliance results were not possible due to the use of tax identification number (TIN) as the unique provider identifier. For example, a single provider could serve individuals across multiple regions, resulting in that provider's compliance score being included in the aggregate score for multiple regions.

## Risk/Harm Compliance Elements

Below are the results for 12 elements that represent core components of the licensed providers' risk management plans and processes. Table 3-4 provides the performance results for the risk management/harm elements.

**Table 3-4: Risk Management/Harm Compliance Elements**

| Compliance Element | Aggregate Type | Result |
|---|---|---|
| Does the agency have someone designated as responsible for risk management functions? | Statewide | 90% |
| Does the agency have a Risk Management plan?* | Statewide | 84% |
| Is there documentation of a systemic review conducted annually of the risk management plan and a quarterly review of serious incidents? | Statewide | 78% |
| Is the Risk Management plan thorough?* | Statewide | 71% |
| The provider implements risk management processes, including the establishment of uniform risk triggers and thresholds, that enable them to adequately address harms and risks of harm.* | Statewide | 83% |
| Does the agency have policies around medical and behavioral health emergencies?* | Statewide | 81% |
| Does the agency have policies that support individuals' participation in financial management and decision making? | Statewide | 71% |
| Does the agency have documentation of a signed lease, residency agreement or other written agreement in place that provides language referencing individual protections from eviction for all persons served? | Statewide | 75% |
| Has the provider made progress on actions identified in the QSR QIP?* | Statewide | 64% |
| Is there evidence of completion of an annual physical exam? | Statewide | 76% |
| Is there evidence of completion of an annual dental exam? | Statewide | 61% |
| Is there an approved modification in place for health and safety risks or is the individual in the process of requesting such approval? | Statewide | 53% |

**Provider service type level tabulation of the provider PQR compliance results were not possible due to the measurement of compliance by provider rather than their specific service type. Region level tabulation of provider PQR compliance results were not possible due to use of tax identification number (TIN) as the unique provider identifier.*

As described in Table 3-4, statewide results revealed a performance of 90 percent or greater compliance for one of twelve elements.

Enhancement opportunities for licensed providers and/or CSBs include ensuring:

- Licensed provider/CSB development of Risk Management Plan; a written plan to identify, monitor, reduce, and minimize harms and risk of harm as defined in 12VAC35-105-520(B), including:
  - Personal injury;
  - Infectious disease;
  - Property damage or loss; and

  - Other sources of potential liability.
- Licensed provider/CSB Risk Management Plan is thorough, as defined by 12VAC35-105-520(D)-520 (F), including expectations that the plan address requirements for:
  - Systemic risk assessment review process that incorporates uniform risk triggers and thresholds as defined by the Department;
  - Safety inspections performed at least annually of each service location owned, rented, or leased by the provider and documenting recommendations for safety improvement and implementation of improvements by the provider;
  - Documenting serious injuries to employees, contractors, students, volunteers, and visitors that occur during the provision of a service or on the provider's property; keeping documentation on file for three years; provider evaluation of serious injuries at least annually; and documenting recommendations for improvement and implementation of improvements by the provider.
- Licensed provider/CSB implementation of risk management processes, including establishment of uniform risk triggers and thresholds, that enable them to adequately address harms and risks of harm, including risk management processes that include uniform risk triggers and thresholds that enable the provider to address harms and risks, or harm and individual file documentation validated application of the risk triggers and thresholds; including a system or process for tracking risk triggers and thresholds (care concerns) as they occur. If the provider has incidents that have met the threshold for a care concern, they are able to document actions they have taken to review the incidents and mitigate risks of future harm.
- Licensed provider/CSB completion of a systemic review of risk management plan annually to identify and respond to practices and situations that could result in the risks of harm to individuals receiving services, addressing at a minimum the environment of care; clinical assessment or reassessment processes; staff competency and adequacy of staffing; use of high-risk procedures including seclusion and restraint; and review of serious incidents at least quarterly.
- Licensed provider/CSB development of policies for medical and behavioral health emergencies
- Licensed residential provider development of policies that support individuals' participation in financial management and decision-making.
- Licensed residential provider development of a lease, residency agreement, or other written agreement that includes eviction protection, specifically regulation VRLTA § 55-248.16.
- Licensed provider/CSB progress on actions identified in QSR QIP.
- Licensed provider/CSB documentation of approval for HCBS Rights modifications, made for health and safety risks, is on file (Safety Restriction Form in WaMS within Part V PFS).
- Licensed residential provider/CSB's documentation of completion of annual physical exam and annual dental exam.

CSB, region, and service type-specific results are available in Appendix I, Appendix Q, and Appendix AD, respectively.

## Incidents Compliance Element

Below are the results for the element that best represents the core component of the licensed providers' incident reporting processes. Table 3-5 provides the performance results for the incident reporting element.

**Table 3-5: Incident Reporting Compliance Element**

| Compliance Element | Aggregate Type | Result |
|---|---|---|
| Reviewer confirms CHRIS incident report spreadsheet is free from patterns of abuse, neglect, or exploitation. | Statewide | 89% |

As described in Table 3-5, statewide results revealed performance of less than 90 percent statewide for the one incident compliance element. Licensed providers were not required to complete a QIP specific to patterns identified but were notified of expectations for addressing those patterns, specifically use of DBHDS guidelines and flow chart for review of incidents. With the goal of increasing positive outcomes and reducing harm as a result of abuse, neglect or exploitation for all individuals receiving provider services, HSAG recommends providers refer to and utilize the "At A Glance Flow Chart for Incident Reviews" developed by DBHDS to establish and/or build upon an internal incident review and mitigation process, including reports of abuse, neglect and exploitation. Licensed providers and CSBs may also reach out to their Regional Advocate Manager with questions about what constitutes a substantiated report (incident) of abuse, neglect, or exploitation and/or for consultation around mitigation strategies.

Provider service type level tabulation of the provider PQR compliance results were not possible due to measurement of compliance by provider rather than their specific service type. Region level tabulation of provider PQR compliance results were not possible due to use of tax identification number (TIN) as the unique provider identifier.

## Provider Capacity and Competency Compliance Elements

Below are the results for 26 elements that represent core components of licensed provider capacity and competency. Table 3-6 provides the performance results for licensed provider capacity and competency elements.

**Table 3-6: Provider Capacity and Competency Compliance Elements**

| Compliance Element | Aggregate Type | Result |
|---|---|---|
| Does the agency have a hiring policy and procedure? | Statewide | 79% |
| Does the policy include requirements around background checks? | Statewide | 91% |
| Does the agency have an orientation training policy for all staff at all levels? | Statewide | 79% |

| Compliance Element | Aggregate Type | Result |
|---|---|---|
| Does the agency have a process written for determining staff competence? | Statewide | 70% |
| Does provider documentation show that the setting has implemented annual HCBS-specific training with all staff? | Statewide | 79% |
| Is there a record of the individual receiving and signing their HCBS rights disclosure on an annual basis? | Statewide | 80% |
| Is the individual's/provider's environment neat and clean? | Statewide | 96% |
| Was the person's/provider's environment accessible? | Statewide | 99% |
| Were staff engaging with the individual based on the person's preferences and interests? | Statewide | 98% |
| Was the person being offered choices throughout the visit? | Statewide | 98% |
| Were staff implementing the Part V as written? | Statewide | 98% |
| For individuals with behavioral support plans, were staff addressing behaviors per the written plan? | Statewide | 100% |
| Were staff adhering to medical and behavioral protocols as outlined in the plan? | Statewide | 99% |
| Were staff able to describe what community inclusion looks like for the individual? | Statewide | 96% |
| Did the staff demonstrate competency in supporting the individual? | Statewide | 100% |
| Are staff familiar with adaptive equipment needs? | Statewide | 97% |
| Were staff utilizing adaptive equipment the individual had as part of their plan? | Statewide | 94% |
| Are staff able to describe things important to and important for the individual? | Statewide | 98% |
| Was the staff able to describe the outcomes being worked on in this environment? | Statewide | 97% |
| Could the staff describe the medical support needs of the individuals? | Statewide | 95% |
| Were the staff familiar with medical protocols to support the person? | Statewide | 95% |
| Could the staff describe behavioral support needs? | Statewide | 97% |
| Were the staff familiar with behavioral support plans or protocols developed to support the person? | Statewide | 95% |
| Does the staff know what medications the person is taking or where to locate this information? | Statewide | 97% |
| Can the staff list the most common side effects of the medications the person is on or where to locate this information? | Statewide | 94% |
| Can you tell me what person-centered care means? | Statewide | 94% |

As described in Table 3-6, statewide results revealed a performance of 90 percent or greater compliance for 21 of 26 elements.

Enhancement opportunities for licensed providers include ensuring:

- Licensed provider development of hiring policy and procedure
- Licensed provider development of orientation training policy for all staff at all levels
- Licensed provider development of written policies that determine staff competence
- Licensed provider implementation of annual HCBS-specific training with all staff (documentation that staff have completed HCBS training within the last year AND that training materials demonstrate all HCBS requirements)
- Licensed provider documentation of individuals' annual review and receipt of HCBS rights disclosure

Below are the results for elements that specifically assess licensed provider medication administration training and crisis intervention training. Table 3-7 provides the statewide results for licensed provider capacity and competency medication administration and crisis intervention training elements.

**Table 3-7: Provider Capacity and Competency Compliance Elements**

| Compliance Element | | | | |
|---|---|---|---|---|
| | When were you last trained on Medication Administration? | | When were you last trained on Crisis Intervention? | |
| **DSP Response** | **>12 months** | **Never** | **>12 months** | **Never** |
| **Statewide** | 9.88% | 5.55% | 6.41% | 1.39% |

All staff interviewed self-reported the last date of training on Medication Administration and Crisis Intervention. Statewide results are offered for information only as DBHDS has not established a compliance threshold for these elements. As described in Table 3-7, 5.55% of staff interviewed have never been trained on Medication Administration and an additional 10% reporting training completed over 12 months prior to date of interview, and less than 2% of staff interviewed have never been trained on Crisis Intervention with an additional 7% reporting training completed over 12 months prior to date of interview.

Region and service type-specific results are available in Appendix R-U, and Appendix AE-AJ, respectively.

Below are the results for elements that specifically assess licensed provider capacity and competency through review of submitted staff records. Table 3-8 provides the statewide results for licensed provider capacity and competency employee records elements.

**Table 3-8: Provider Capacity and Competency Compliance Elements**

| Compliance Element | Aggregate Type | Result |
|---|---|---|
| How many employee records had proof of background checks? | Statewide | 95% |
| How many employee records had documentation of provider-based orientation training? | Statewide | 94% |

| Compliance Element | Aggregate Type | Result |
|---|---|---|
| How many employee records have proof of competency-based training? | Statewide | 91% |
| How many employees serving someone in tier 4 have documentation of advanced competency training? | Statewide | 84% |

As described in Table 3-8, statewide results revealed a performance of 90 percent or greater compliance for three of four elements.

Enhancement opportunities for licensed providers include ensuring:

- Licensed provider staff members who serve individuals in tier 4 have documentation of advanced competency training

Provider service type level tabulation of the provider PQR compliance results were not possible due to measurement of compliance by provider rather than their specific service type. Region level tabulation of provider PQR compliance results were not possible due to use of tax identification number (TIN) as the unique provider identifier.

## *Provider Capacity and Competency HSW Alert Elements*

Below are 15 compliance elements that were identified by DBHDS as requiring a *Provider Capacity and Competency (PC&C) HSW Alert*. Providers who were assessed as deficient for any element below were documented and communicated to DBHDS for follow-up and further data analysis.

Table 3-9 lists PQR *Provider Capacity and Competency HSW Alert* elements.

**Table 3-9: PQR Provider Capacity and Competency HSW Alert Elements**

| PQR Provider Competency & Capacity HSW Alert Elements |
|---|
| How many licensed provider employee records had documentation of provider-based orientation training? |
| How many licensed provider employee records have proof of competency-based training? |
| How many licensed provider employees serving someone in tier 4 have documentation of advanced competency training? |

Table 3-10 lists PCR *Provider Capacity and Competency (PC&C) HSW Alert* elements.

**Table 3-10: PCR Provider Capacity and Competency HSW Alert Elements**

| PCR Provider Capacity and Competency HSW Alert Elements |
|---|
| For individuals with behavioral support plans, were staff addressing behaviors per the written plan? |
| Were staff adhering to medical and behavioral protocols as outlined in the plan? |
| Did the staff demonstrate competency in supporting the individual? |
| If yes, was there evidence of oversight and monitoring of the new staff? |
| Are staff able to describe things important to and important for the individual? |
| Was staff able to describe the outcomes being worked on in this environment? |
| Could the staff describe the medical support needs of the individuals? |
| Were staff familiar with medical protocols to support the person? |
| Could the staff describe behavioral support needs? |
| Were staff familiar with behavioral support plans or protocols developed to support the person? |
| Does the staff know what medications the person is taking or where to locate this information? |
| Can the staff list the most common side effects of the medications the person is on or where to locate this information? |

## *Community Integration and Inclusion Elements*

Below are the results for three elements that best represent core components of community integration and inclusion. Table 3-11 provides the performance results for community integration and inclusion elements.

**Table 3-11: Community Integration and Inclusion Compliance Elements**

| Compliance Element | Aggregate Type | Result |
|---|---|---|
| Does the licensed provider promote individual participation in what the individual considers to be meaningful work activities? | Statewide | 93% |
| Does the licensed provider promote individual participation in non-large group activities? | Statewide | 96% |
| Does the licensed provider encourage individual participation in community outings with people other than those with whom they live? | Statewide | 96% |

As described in Table 3-11, statewide results revealed a performance of 90 percent or greater compliance for all three elements.

Provider service type level tabulation of the provider PQR compliance results was not possible due to the measurement of compliance by the licensed provider rather than their specific service type. Region-level tabulation of provider PQR compliance results were not possible due to the use of tax identification number (TIN) as the unique provider identifier.

## Individual Interview Results

HSAG aggregated individual interview results, consisting of 22 interview questions scored using individual self-reports, into statewide percentages and using a standard compliance cutoff of 90 percent to identify areas with opportunities for improvement.

Table 3-12 displays the aggregate results of individual interview responses.

**Table 3-12: Individual Interview Responses**

| Aggregate Individual Interview Responses | | | | |
|---|---|---|---|---|
| **Individual Interview Questions** | **Percent Yes** | **Percent No** | **Percent CND[1]** | **Percent Positive[2] (Yes/Yes+No)** |
| Do you like living here? | 85% | 5% | 10% | 95% |
| Would you like to live somewhere else?[3] | 27% | 54% | 19% | 34% |
| Did you choose the people you live with? | 61% | 17% | 22% | 78% |
| Do you have a key to your home? | 68% | 18% | 14% | 79% |
| Do you have a key to your bedroom? | 51% | 32% | 16% | 61% |
| Do you open your mail or help with opening your mail? | 76% | 7% | 17% | 92% |
| Do you have visitors at your home? | 81% | 5% | 14% | 94% |
| Do you like attending this program? | 87% | 4% | 9% | 96% |
| Did you get to choose the people you participate in the group with? | 77% | 5% | 18% | 94% |
| Would you like to do something else during the day?[3] | 28% | 47% | 25% | 37% |
| Do you like your staff? | 89% | 2% | 9% | 98% |
| If you want to go somewhere, does your provider take you? | 82% | 2% | 16% | 98% |
| Can you get where you want to go without problems? | 74% | 5% | 20% | 93% |
| Do you get to do those things as much as you would like? | 65% | 12% | 24% | 85% |
| Do you want to attend a church/synagogue/mosque or other religious activity of your choice? | 55% | 28% | 18% | 66% |
| Do you attend religious services? | 48% | 35% | 16% | 58% |
| Are you registered to vote? | 42% | 31% | 27% | 57% |
| Did you vote in the last election? | 30% | 40% | 30% | 43% |
| Do you participate in your banking? | 53% | 27% | 20% | 66% |
| Do you have a job? | 24% | 62% | 14% | 28% |
| Is your support coordinator currently addressing your employment goals? | 70% | 12% | 18% | 85% |
| Do you feel safe here? | 84% | 4% | 12% | 96% |

*[1]CND: could not determine (individual's response was unable to be understood/determined)*

*[2]Percent Positive is the percentage of Yes responses divided by the sum of Yes+No responses to the question. The CND response is not utilized to calculate this performance.*

*[3]These compliance elements were measured using scoring criteria that are inverse, meaning a lower percentage indicates better compliance. Compliance cut-off standards remained the same, hence compliance percentages greater than 10% indicate areas with opportunities for improvement.*

Strengths include:

- Individuals like their staff
- Individuals like where they live
- Individuals feel safe where they live
- Individuals have visitors where they live
- Individuals open their mail
- Individuals choose the people in their group program
- Individuals like attending community-based programs
- Individuals do not experience barriers to accessing their community

Opportunities for licensed providers and CSBs include:

- Supporting individuals to participate in daily activities of their choice as frequently as possible
- Supporting individuals to address current employment goals with their support coordinator
- Increasing options for individuals to participate in religious activities of their choice
- Supporting individuals to participate in their banking
- Providing keys to residence and/or personal bedroom
- Supporting individuals in registering to vote
- Providing individual choice of housemate(s)

Region and service type-specific results are available in Appendix AK-AL.

## *Substitute Decision Maker (SDM)/Family Interview Results*

HSAG aggregated SDM/Family interview results, consisting of 7 interview questions scored using SDM/Family self-report, into statewide percentages and using a standard compliance cutoff of 90 percent to identify areas with opportunities for improvement. Substitute decision-makers, family members, and/or legal guardians are not required to participate in the QSR interview.

**Table 3-13: SDM/Family Interview Responses**

| Aggregate SDM/Family Interview Responses | | | | |
|---|---|---|---|---|
| **SDM/Family Interview Questions** | **Percent Yes** | **Percent No** | **Percent Not Sure[2]** | **Percent Positive[1] (Yes/Yes+No)** |
| Did the SC provide the individual with a choice in service providers, including a choice in SC? | 89% | 6% | 5% | 94% |
| Did the SC discuss employment goals and options with the individual? | 87% | 7% | 6% | 92% |
| Did the SC discuss community involvement opportunities with the individual? | 92% | 4% | 4% | 96% |
| Are all of the individual's needs and supports currently being met? | 86% | 13% | 2% | 87% |
| Did you have an opportunity to participate in the ISP development? | 95% | 3% | 1% | 97% |
| Do you feel the ISP is representative of the person's needs? | 95% | 2% | 3% | 98% |
| Does the SDM/Family confirm there are no concerns regarding the current service providers? | 87% | 13% | - | 87% |

[1]*Percent Positive is the percentage of Yes responses divided by the sum of Yes+No responses to the question. The "Not Sure" response is not utilized to calculate this performance.*

[2]*Not Sure: SDM/Family is not certain.*

SDM/Family member responses statewide indicate 90% or greater compliance for five of seven elements above. Based on SDM/family member report, strengths include:

- SC provides the individual with a choice of service providers, including a choice in SC
- SC discussing employment goals and options with the individual
- SC discussing community involvement opportunities with the individual
- The SDM/Family has an opportunity to participate in ISP development
- The ISP is representative of the person's needs

The compliance elements which fell below the state standard are self-report data collected through interviews with natural supports or family members, SDM, and legal guardians. Opportunities for licensed providers/CSBs include ensuring:

- Ensuring SDM/Family members' opinions and concerns are considered and addressed as appropriate, including concerns about current service providers and/or the individual's needs and supports being met.

Region and service type-specific results are available in Appendix AM-AN.

# 4. Conclusions and Recommendations

## Conclusions

The results of the R5 QSR provide evidence that in general, statewide:

1. Licensed providers/CSBs have someone designated as responsible for risk management functions who have completed department approved training and training attestation.
2. Licensed providers/CSBs have a quality improvement plan.
3. Licensed providers have policies and procedures that address Home and Community-Based Services (HCBS) rights.
4. Licensed providers/CSBs were able to demonstrate methods or strategies to promote participation in activities that represent meaningful work as determined by the individual, non-large group activities, and community outings with people other than those with whom they live.
5. Licensed providers/CSBs hiring policy includes requirements for background checks.
6. Employee records reviewed for licensed providers/CSBs included proof of background checks, provider-based orientation training, and competency-based training.
7. The ISP was developed with 365 days of the previous ISP.
8. The ISP Part II includes communication, assistive technology, and modification needs; employment status and assessment of barriers to employment; meaningful day and community involvement status; prescribed medications; and social and developmental behavioral family history.
9. The ISP has outcomes developed in the life areas of integrated community involvement, community living, safety and security, citizenship and advocacy, and healthy living, as appropriate.
10. The ISP and/or other documentation supports that the individual had support from people during the development of the ISP that they wanted, was given a choice regarding services and supports, including the individual's residential setting, and who provides them, and includes signatures of the individual or their representative and all licensed providers responsible for its implementation.
11. Licensed provider and individual environments are neat, clean, and accessible.
12. Staff is knowledgeable about the medications the individual is taking and the common side effects of those medications, or where to find that information.
13. Staff observations demonstrated that staff were engaging with the individual based on the person's preference and interest.
14. Staff observations demonstrated that individuals were being offered choices throughout the visit.
15. The service that the observed staff provided to the individual reflects the implementation of the ISP Part V as written.
16. The staff utilized strategies identified in the behavioral support plan to support the individual, if applicable.
17. The staff utilized medical and behavioral protocols to support the individual as outlined in the plan
18. The staff demonstrated competence in supporting the individual.

19. The staff supported the individual utilizing the adaptive equipment as indicated in the ISP, if applicable.
20. Staff interviews demonstrated that staff was able to describe things important to and important for the individual.
21. Staff interviews demonstrated that staff were able to describe the outcomes being worked on in this environment, for the individual(s) served.
22. Staff interviews demonstrated that staff were able to describe and were familiar with the medical and/or behavioral support needs of the individual and any signs/symptoms that need to be monitored.

The R5 QSR results demonstrate:

- A 90 percent or greater compliance for three of nine Individual Service Plan (ISP) Assessment elements
- A 90 percent or greater compliance for 10 of 24 ISP Development and Implementation elements
- A 90 percent or greater compliance for two of 10 Quality Improvement plan elements
- A 90 percent or greater compliance for one of 12 Risk/Harm elements
- A 90 percent or greater compliance for zero of one Incident element
- A 90 percent or greater compliance for 24 of 30 Licensed Provider Capacity and Competency elements
- A 90 percent or greater compliance for three of three Community Integration and Inclusion elements

CSBs and licensed providers must maintain a quality improvement program for all elements assessed in the QSR, not just the elements with a QIP to ensure continued demonstrable compliance.

## Recommendations for Quality Improvement

Of the total number of licensed providers and CSBs who participated in R5 QSR 257 licensed providers and 39 CSBs received detailed reports noting specific deficiencies and opportunities for improvement that required submissions of QIP responses. Licensed provider/CSB response and/or action was required for any compliance element with a score less than 90 percent. Licensed providers/CSBs submitted QIPs to HSAG for review and approval and the status of implementation of those QIPs will be assessed during the next QSR the licensed provider/CSB is selected to participate in.

Opportunities for improvement statewide can generally be sorted into three areas: service plan development and/or implementation, service provision, and quality improvement/risk management activities and are offered to address specific compliance elements assessed as not meeting the statewide standard by licensed providers and/or CSBs in QSR R5. The purpose of recommendations listed here and detailed in Table 4-1 are to assist licensed providers and/or CSBs to identify and address deficient findings from the QSR and incorporate those findings into QI activities to a) ensure continuum of care for the individuals served, b) ensure compliance with all relevant DBHDS regulations and best practices,

and c) improve overall quality of service planning and service provision by licensed providers and CSBs.

Listed below are QSR compliance elements specific to individual service planning that did not meet the statewide standard for compliance in R5. Service planning development and/or implementation improvements for CSBs should include:

- Accurate documentation of all medical and behavioral evidenced in the SIS®;
- Development of the ISP Part I that is complete, thorough, and accurately reflects the individual, specifically containing adequate information for a reader to have a good idea of the individual's specific likes, preferences, and how the person is best supported, ensuring ISP planning is person-centered, including strategies to resolve conflict that may arise during ISP planning;
- Timely completion of the RAT to best integrate high-risk health factors and potential risks into the ISP as appropriate;
- An annual assessment that includes all information related to the person's ISP;
- Development of the ISP which includes all health and behavioral support needs, and physical and health conditions;
- Development of outcomes in the ISP for all relevant life areas as required;
- Development of the ISP with all needs identified included in outcomes with assigned responsible provider and plan for supports;
- Development of the ISP according to processes required;
- Completion of additional assessments that may address deficiencies in functional needs as appropriate, and/or appropriate incorporation of assessments completed after initiation of the ISP into the current plan;
- Documentation of the most recent annual physical and dental exams;
- Review of the ISP with the individual every 90 days; and
- Giving individuals a choice regarding services and supports, including who provides them.

The following recommendations are suggested to address deficient QSR findings specific to Individual Service Planning and assist CSBs with the incorporation of findings into QI activities. HSAG recommends CSBs:

1. Identify key sources of variability related to deficiencies in ISP development and/or implementation to effectively mitigate those sources of error.
2. Address QSR deficiencies with systemic approaches and interventions, rather than singular actions to address individual findings, to better identify system-wide barriers and patterns within the CSB, including known barriers impacting the statewide system such as staffing shortages.
3. Develop policies and processes to mitigate the potential impact of staffing shortages and/or staffing turnover on CSB capacity to execute best practices for ISP development and implementation,

specifically policies that specify how to prioritize case management needs for individuals when staffing shortages impact ability of CSB to maintain timely visits or review of the ISP.

4. Develop policies and processes pertinent to maintaining a continuum of care in the context of staffing shortages and turnover that reflects appropriate and continual assessment of all individuals for changes in status, including those that may require immediate action, with the goal of consistent monitoring for slow decline or changes over time when individual does not have consistent case management supports.

Listed below are QSR compliance elements specific to service provision that did not meet the statewide standard for compliance in R5. Service provision improvements for licensed providers and/or CSBs who offer waiver services should include:

- Review of HCBS rights with individuals annually as required, development of policies specific to assurance of individual choice and self-determination and dignity of risk and confirming modifications for health and safety risks have appropriate approval;
- Development of policies by licensed providers of residential services that support individual' participation in financial management and decision making;
- Development by licensed providers of residential services of residency agreements or other written protections from eviction are in place for individuals the serve;
- Development of hiring policies and procedures;
- Development of an orientation training policy for all staff levels;
- Implementation of annual HCBS specific training for all staff; and
- Development and monitoring of policies that specify provider process for determining staff competence.

The following recommendations are suggested to address deficient QSR findings specific to service provision and assist licensed providers and/or CSBs with incorporation of findings into QI activities. HSAG recommends that licensed providers and CSBs who offer waiver services:

1. Identify systemic deficiencies in implementation of HCBS settings rules, across programs, service types, and settings.
2. Ensure policies specific to dignity of risk and individual choice and determination are in place, ensure staff have a working understanding of the concepts represented in each policy, and how they apply to the individuals served by the licensed provider and/or CSB.
3. Develop and implement policies and processes specific to hiring, orienting, and training staff, and policies and/or processes that detail how staff competence is determined and maintained.
4. Continue to incorporate the potential impact of staffing shortages and staff turnover into systemic interventions specific to hiring, training, and maintaining competent staff.

Listed below are QSR compliance elements specific to QI/RM activities that did not meet the statewide standard for compliance in R5. Quality Improvement/Risk Management (QI/RM) activity improvements for licensed providers and/or CSBs should include:

- The development of a risk management plans by licensed providers and CSBs, which include an annual systemic risk review and quarterly review of serious incidents.
- Licensed providers/CSBs should increase their capacity to implement and monitor QI/RM activities which adequately identify risks of harm specific to the individuals they serve.
- Development by licensed providers/CSBs of a Quality Improvement program policy/procedure that details how providers track community inclusion for individuals receiving services, specifically how the provider determines if its personnel promote meaningful work and participation in non-large group activities, and how personnel encourage participation in community outings with people other than those with whom they live.
- Development by licensed providers/CSBs of a Quality Improvement plan that includes all aspects of Virginia regulatory code 12VAC35-105-620 A-E as required, including how the provider plans to and/or is addressing any findings born out of the execution of the QI Program Policy and Procedure related to provider tracking of community inclusion for individuals receiving services, including appropriate implementation of the process to track community inclusion, outcome of that process, and remediation steps to address any findings.
- Development by licensed providers/CSBs of a Risk Management Plan that includes all aspects of Virginia regulatory code 12VAC35-105-160(C), 12VAC35-105-520(C)(5), and 12VAC35-105-520(D) as required.
- Review of licensed providers'/CSBs' active QI plan annually.
- Incorporation of QSR findings into licensed providers'/CSBs' QI/RM processes as appropriate.

The following recommendations are suggested to address deficient QSR findings specific to licensed provider/CSB QI/RM activities and assist licensed providers/CSBs with incorporation of findings into QI activities. HSAG recommends that licensed providers/CSBs:

1. Utilize QSR findings in tandem with the most current DBHDS tools, resources, and training materials to ensure QI/RM policies, procedures, and processes include all required aspects.
2. Identify key sources of systemic variability related to the inability to proactively identify and address risks of harm for the individuals they serve, such as competency of staff designated and responsible for risk management, turnover of staff responsible for the monitoring of risks for individuals, or other systemic factors, to effectively mitigate those sources of error.
3. Develop policies and processes that track community inclusion for the individuals they serve, and incorporate any findings born out of tracking of those activities into QI/RM plans.

The following recommendations are suggested for DBHDS to support licensed providers and/or CSBs in addressing statewide deficiencies in Individual Service Planning, service provision, and/or QI/RM activities, using systemic analysis and interventions. HSAG recommends DBHDS consider the following statewide actions to address findings in R5 QSR.

1. Continue to define and communicate best practice expectations to CSBs through development of training curriculum, or utilization of current trainings with this curriculum, for targeted supports specific to:

a) Identifying, documenting, and addressing changes in status by support coordinators, including how to recognize changes in status that occur over time,
b) Recognizing when a new assessment requires a change to in-progress ISP
c) Recognizing when a new assessment may be indicated, and/or when intervention or action is most appropriate or required to address the change
d) How to properly mitigate and document efforts to mitigate current risks and/or new risks secondary to change in status including when the individual and/or their representative declines referral for assessment or additional supports.

2. Confirm CSB's knowledge and understanding of new regulations specific to case management activities, as detailed in 12VAC35-35-112.
3. Confirm QSR tools and compliance elements specific to ISP development and implementation are updated with relevant case management regulations where applicable to better assist CSBs in incorporating DBHDS standards into best practices via future rounds of the QSR.
4. Ensure CSB access to and utilization of the most current DBHDS support coordinator competencies that reflect best practices for ISP development and implementation for CSBs for incorporation into hiring and training activities.
5. Incorporation of thresholds into the RAT for identification of cumulative risk(s) that clearly identifies for staff completing the assessment when action is required to mitigate of these risk factors.
6. Develop and communicate best practice expectations for CSBs pertinent to maintaining a continuum of care in the context of staffing shortages and/or high staff turnover that reflects appropriate and continual assessment of all individuals for changes in status, including those that may require immediate action, with the goal of consistent monitoring for changes to needs or status including slow decline or changes over time.
7. Continue to clarify and communicate expectations for implementation of HCBS settings rule policies and procedures for CSBs, including CSBs that do not provide waiver services outside of case management.
8. Continue to define and communicate best practice expectations through targeted trainings with most current DBHDS curriculum for licensed providers and CSBs best specific to:
   a) Policies and processes specific to hiring, orienting, and training staff, including assessing staff competence
   b) Clarify and communicate expectations for completion of advanced competencies by staff that serve individuals in SIS® Level 5 Tier 4
   c) The development of processes to track community inclusion for the individuals they serve.
9. Identify key sources of provider specific variability related to an inability to proactively identify and address risks, such as the size of the provider, length of time providing services, competency of staff designated as responsible for risk management activities, and/or availability of appropriate local resources to mitigate the complex medical and behavioral risks of individuals statewide.
10. Continue to develop and disseminate trainings with a curriculum that detail key components of QI/RM activities, including new regulations and/or best practices.

11. Provide targeted support to assist licensed providers and CSBs in developing or revising QI/RM programs to ensure the inclusion of key components of QI/RM activities, including findings from QSR pertinent to quality improvement and/or risk management activities.

HSAG reviewed the statewide, CSB, region, and service type-specific aggregate results and offered the following recommendations:

**Table 4-1: Opportunities for Improvement and Recommendations**

| Service Type Definitions | |
|---|---|
| Agency Directed Respite – ADR | Group Residential Support <= 4 Persons – GRS |
| Case Management – CMA | Group Residential Support > 4 Persons – GRL |
| Community Coaching – CCO | Independent Living Supports – ILS |
| Community Engagement – CEN | In-Home Supports – IHS |
| Group Day – GDY | Sponsored Residential – SPR |
| Group Home (Customized Rate) – GHC | Supported Living – SUL |

| Element | Opportunity for Improvement |
|---|---|
| Were any assessments completed after the initiation of the ISP and used to inform changes to the ISP? | **Statewide**: 48%<br>**Regions with opportunity**: 1, 2, 3, 4, 5<br>**Service types with opportunity**: CCO, CEN, GDY, GHC, GRS, GRL, ILS, IHS, SPR, SUL<br>**Recommendation:** HSAG recommends that CSBs ensure support coordinator understanding of the best practice expectations for ISP updates/changes by providing additional clinical-based training and/or DBHDS published resources to all support coordinators focusing on the integration of relevant assessments into current ISP.<br><br>HSAG recommends DBHDS continue to define and communicate best practice expectations for identifying, documenting, and referring for assessment by support coordinators, including how to recognize change in status that occurs over time, and/or when ISP revision is appropriate or required to address the change. HSAG recommends DBHDS assess CSB usage and understanding of current ISP |

| Element | Opportunity for Improvement |
|---|---|
| | system for functionality specific to changes and/or updates to an in-progress ISP and consistent application of best practices specific to ISP changes. |
| Does the ISP incorporate high-risk health factors identified in the RAT? | **Statewide**: 61%<br>**Regions with opportunity**: 1, 2, 3, 4, 5<br>**Service types with opportunity**: CCO, CEN, GDY, GHC, GRS, GRL, ILS, IHS, SPR, SUL<br>**Recommendation:** HSAG recommends that CSBs ensure support coordinator understanding of the expectations for incorporation of all risks and potential risks related to high-risk health factors into the ISP, by providing additional clinical-based training and/or DBHDS published resources to all support coordinators focusing on the incorporation of RAT in ISP planning, specifically the expectation that SC ensure all risks and potential risks are noted in Part II of the ISP, and that all risks or potential risks are addressed in Part III Outcome or have notation regarding mitigation of that risk or potential risk when the development of outcome has been declined, including ensuring referrals to Qualified Health Professional (QHP) have been completed when indicated.<br><br>HSAG recommends DBHDS ensure CSBs have knowledge of and access to the most current DBHDS training materials detailing best practices for ISP development, specifically incorporation of high-risk health factors into the ISP. HSAG recommends incorporating threshold(s) into the RAT that identify when action is required to address cumulative risk factors, and development of best practices specific to mitigation of high-risk health factors when individual and/or their representative declines assessment, evaluation, referrals, or supports to address the risk(s). |
| Is Part I of the ISP complete and thorough? | **Statewide**: 81%<br>**Regions with opportunity**: 1, 3, 4, 5<br>**Service types with opportunity**: ADR, CCO, CEN, GDY, GHC, GRS, GRL, ILS, IHS, SPR<br>**Recommendation**: HSAG recommends that CSBs ensure support coordinator understanding of the expectation for ISP Part I documentation, specifically the minimum requirement that details are written in person-centered language and includes individuals |

| Element | Opportunity for Improvement |
|---|---|
| | meeting details, talents, and contributions, what is important to and for the individual and what s/he does and does not want, and addresses all life areas for the individual including a preference to not develop outcome in a life area, by providing additional clinical-based training and/or DBHDS published resources focusing on critical aspects of person-centered planning to all support coordinators.<br><br>HSAG recommends DBHDS ensure CSBs have knowledge of and access to the most current DBHDS training materials detailing best practices for complete and thorough ISP development. |
| Does the assessment include all information related to the person's ISP? | **Statewide**: 66%<br>**Regions with opportunity**: 1, 2, 3, 4, 5<br>**Service types with opportunity**: ADR, CCO, CEN, GDY, GHC, GRS, GRL, ILS, IHS, SPR, SUL<br>**Recommendation:** HSAG recommends that CSBs ensure support coordinator understanding of assessment activities which should be completed in conjunction with annual ISP planning and development, specifically taking individual's socio-developmental history, identifying the individual's needs, including known and potential risks, and gathering information from all relevant parties such as family members and other service providers.<br><br>HSAG recommends DBHDS continue to refine and communicate to CSBs best practice expectations for annual ISP assessment activities, including how to document evidence of those activities within the ISP system and/or CSB notation. |
| Does the ISP Part II include the individual's health and behavioral support needs? | **Statewide**: 70%<br>**Regions with opportunity**: 1, 2, 3, 4, 5<br>**Service types with opportunity**: CCO, CEN, GDY, GHC, GRS, GRL, ILS, IHS, SPR, SUL<br>**Recommendation**: HSAG recommends that CSBs ensure support coordinator understanding of the expectation for ISP Part II documentation, specifically the inclusion of individual's essential information, health information, and behavioral and/or crisis support needs as reflected in most recent assessments |

| Element | Opportunity for Improvement |
|---|---|
| | by providing additional clinical-based training and/or DBHDS published resources focusing on inclusion of all relevant health and behavioral support needs in ISP planning documentation to all support coordinators.<br><br>HSAG recommends DBHDS ensure CSBs have knowledge of and access to the most current DBHDS training materials detailing best practices for ISP development. |
| Does the ISP Part II include the individual's physical and health conditions? | **Statewide**: 78%<br>**Regions with opportunity**: 1, 2, 3, 4, 5<br>**Service types with opportunity**: ADR, CEN, GDY, GHC, GRS, GRL, ILS, IHS, SPR, SUL<br>**Recommendation:** HSAG recommends that CSBs ensure support coordinator understanding of best practice expectations for accurate and through completion of ISP Part II, specifically inclusion of essential information, allergies, last exam dates, and physical and health conditions identified in relevant assessments.<br><br>HSAG recommends DBHDS ensure CSBs have knowledge of and access to the most current DBHDS training materials detailing best practices for ISP development. |
| The ISP reviewed identified all medical needs found in the SIS® or other relevant assessments. | **Statewide**: 72%<br>**Regions with opportunity**: 1, 2, 3, 4, 5<br>**Service types with opportunity**: ADR, CCO, CEN, GDY, GHC, GRS, GRL, ILS, IHS, SPR, SUL<br>**Recommendation**: HSAG recommends that CSBs ensure support coordinator understanding of the expectation for ISP Part II documentation of all medical needs identified in most recent assessments by providing additional clinical-based training and/or DBHDS published resources focusing on proper identification and inclusion of all medical needs documented in most recent assessments to all support coordinators.<br><br>HSAG recommends DBHDS ensure CSBs have knowledge of and access to the most current DBHDS |

| Element | Opportunity for Improvement |
|---|---|
| | training materials detailing best practices for ISP development, specifically inclusion of all medical needs identified in relevant assessments into current ISP. |
| The ISP reviewed identified all behavioral needs found in the SIS® or other relevant assessments. | **Statewide**: 69%<br>**Regions with opportunity**: 1, 2, 3, 4, 5<br>**Service types with opportunity**: ADR, CCO, CEN, GDY, GHC, GRS, GRL, ILS, IHS, SPR, SUL<br>**Recommendation**: HSAG recommends that CSBs ensure support coordinator understanding of the expectation for ISP Part II documentation of all behavioral needs identified in most recent assessments by providing additional clinical-based training and/or DBHDS published resources focusing on proper identification and inclusion of all behavioral needs documented in most recent assessments to all support coordinators.<br><br>HSAG recommends DBHDS ensure CSBs have knowledge of and access to the most current DBHDS training materials detailing best practices for ISP development, specifically inclusion of all behavioral needs identified in relevant assessments into current ISP. |
| Was the RAT completed timely? | **Statewide**: 84%<br>**Regions with opportunity**: 1, 3, 4, 5<br>**Service types with opportunity**: CCO, CEN, GDY, GHC, GRS, GRL, ILS, IHS, SPR<br>**Recommendation**: HSAG recommends that CSBs, ensure support coordinator understanding of the expectation for completion of the RAT prior to, or in conjunction with, ISP planning.<br><br>HSAG recommends DBHDS ensure CSBs have knowledge of and access to the most current DBHDS training materials detailing best practices for completion of RAT. |
| Are any additional assessments needed for conditions listed?[1] | **Statewide**: 37%<br>**Regions with opportunity**: 1, 2, 3, 4, 5 |

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| | **Service types with opportunity**: CCO, CEN, GDY, GHC, GRS, GRL, ILS, IHS, SPR, SUL<br>**Recommendation:** HSAG recommends DBHDS develop and disseminate best practice expectations for completion of additional assessment or referral for further evaluation of individuals' medical and behavioral needs, specifically: communication needs; diet or nutritional needs; complex medical needs or current nursing services; needs secondary to limited mobility; behavioral and/or mental health supports; or medication side effect management. |
| Are all risks identified in Part II of the ISP addressed under an outcome in Part III? | **Statewide**: 73%<br>**Regions with opportunity**: 1, 2, 3, 4, 5<br>**Service types with opportunity**: ADR, CCO, CEN, GDY, GHC, GRS, GRL, ILS, IHS, SPR, SUL<br>**Recommendation**: HSAG recommends that CSBs ensure the support coordinator's understanding of the expectation for inclusion of any risk identified in ISP Part II documentation to be included in Part III outcomes or include adequate notation regarding why the outcome was not developed for that risk, by providing additional clinical-based training and/or DBHDS published resources focusing on proper inclusion of all risks in the appropriate Part III outcome.<br><br>HSAG recommends DBHDS ensure CSBs have knowledge of and access to the most current DBHDS training materials detailing best practices for ISP development. |
| Outcomes are developed in the life area of Employment as appropriate. | **Statewide**: 81%<br>**Regions with opportunity**: 2, 3, 4, 5<br>**Service types with opportunity**: ADR, CCO, CEN, GDY, GHC, GRS, GRL, ILS, IHS, SPR<br>**Recommendation:** HSAG recommends that CSBs ensure support coordinator's understanding of the expectations for ISP Part III outcome development including best practice documentation when individual preference is to not develop outcome in the life area of Employment. |

| Element | Opportunity for Improvement |
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| | HSAG recommends DBHDS continue to communicate best practice expectations to CSBs regarding development of ISP outcomes in the Employment life area and how to best document conversations during ISP planning and development that reflect individuals' choice to not develop outcomes in a specific life area. |
| Outcomes are developed in the life area of Social & Spirituality as appropriate. | **Statewide**: 84%<br>**Regions with opportunity:** 1, 2<br>**Service types with opportunity**: CCO, GDY, GRS, GRL, ILS, IHS, SPR, SUL<br>**Recommendation:** HSAG recommends that CSBs ensure the support coordinator's understanding of the expectations for ISP Part III outcome development including best practice documentation when individual preference is to not develop outcome in the life area of Social & Spirituality.<br><br>HSAG recommends DBHDS continue to communicate best practice expectations to CSBs regarding development of ISP outcomes in Social & Spirituality life area and how to best document conversations during ISP planning and development that reflect individuals' choice to not develop outcomes in a specific life area. |
| Are all needs in Part II assigned to Part III Outcome, including the responsible provider? | **Statewide**: 83%<br>**Regions with opportunity**: 1, 3, 4, 5<br>**Service types with opportunity**: ADR, CEN, GDY, GHC, GRS, GRL, IHS, ILS, SPR, SUL<br>**Recommendation:** HSAG recommends that CSBs ensure the support coordinator's understanding of the expectation for inclusion of any need identified in ISP Part II documentation to be assigned to Part III outcomes including responsible provider, by providing additional clinical-based training and/or DBHDS published resources focusing on proper inclusion of all needs in Part III outcomes.<br><br>HSAG recommends DBHDS continue to communicate best practice expectations to CSBs regarding inclusion of all needs in Part II of the ISP |

| Element | Opportunity for Improvement |
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| | into ISP Part III outcomes with appropriate responsible provider assigned. |
| Are all outcomes identified in Part III linked to Part V PFS as appropriate? | **Statewide**: 89%<br>**Regions with opportunity**: 1, 3, 4<br>**Service types with opportunity**: ADR, CEN, GDY, GHC, GRL, SPR<br>**Recommendation:** HSAG recommends that CSBs ensure the support coordinator's understanding of the expectation for inclusion of any Part III outcome in Part V plan for supports for assigned provider, by providing additional clinical-based training and/or DBHDS published resources focusing on appropriate linkage of Part III outcomes to Part V plan for supports.<br><br>HSAG recommends DBHDS continue to communicate best practice expectations to CSBs regarding expectation for linkage of any Part III outcome into a Part V plan for supports. |
| Does the ISP include strategies for solving conflict or disagreement that occurs during the ISP meeting regarding ISP supports, outcomes, or individual decisions? | **Statewide**: 85%<br>**Regions with opportunity**: 2, 5<br>**Service types with opportunity**: CCO, CEN, GRS, ILS, IHS<br>**Recommendation:** HSAG recommends CSBs ensure support coordinators understand what types of conflict may arise during ISP planning, specifically as they relate to the implementation of person-centered practices, to better prepare support coordinators for the role of advocacy during ISP development. HSAG recommends that CSBs ensure the support coordinator's understanding of best practice expectations for documentation and notation of conflict and subsequent resolution which may occur during ISP planning in progress note that details ISP planning meeting.<br><br>HSAG recommends DBHDS continue to communicate best practice expectations to CSBs regarding documentation of conflict or disagreement and subsequent resolution that occurs during ISP planning. |

| Element | Opportunity for Improvement |
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| The ISP and/or other SC documentation confirmed a review of the ISP was conducted with the individual quarterly or every 90 days. | **Statewide**: 73%<br>**Regions with opportunity**: 1, 2, 3, 4, 5<br>**Service types with opportunity**: ADR, CCO, CEN, GDY, GHC, GRS, GRL, IHS, SPR, SUL<br>**Recommendation:** HSAG recommends that CSBs ensure the support coordinator's understanding of the expectation that ISP review will occur with each individual quarterly or every 90 days. HSAG recommends CSBs identify key sources of systemic variability related to the timely completion of quarterly reviews to identify if late entry is due to staff error, staff turnover, late submission by the licensed provider, or other reasons, to effectively mitigate that source of error. HSAG recommends CSBs develop policies and processes specific to ensuring timely review of ISP for all individuals when staffing issues impact completion of required case management activities.<br><br>HSAG recommends DBHDS develop strategies and/or best practice guidelines for CSBs to prioritize completion of required case management activities when staff shortages impact these activities. |
| The ISP and/or other documentation supports that the individual was given a choice regarding services and supports, including the individual's residential setting, and who provides them. | **Statewide**: 88%<br>**Regions with opportunity**: 4, 5<br>**Service types with opportunity**: ADR, GDY, GHC, GRS, GRL, ILS, IHS, SPR, SUL<br>**Recommendation:** HSAG recommends CSBs ensure support coordinator understanding of accurate completion of Virginia Informed Choice for all supports and services, including support coordination.<br><br>HSAG recommends DBHDS continue to communicate revisions about and provide training specific to the proper completion of the Virginia Informed Choice form. |
| The ISP and/or the individual's file included documentation the support coordinator identified and resolved any unidentified or inadequately addressed risk, injury, need, or change in status, a deficiency in the individual's support plan or its implementation, or | **Statewide**: 20%<br>**Regions with opportunity**: 1, 2, 3, 4, 5<br>**Service types with opportunity**: ADR, CCO, CEN, GDY, GHC, GRS, GRL, ILS, IHS, SPR, SUL |

| Element | Opportunity for Improvement |
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| a discrepancy between the implementation of supports and services and the individual's strengths and preferences. | **Recommendation**: HSAG recommends that CSBs provide additional clinical-based training focusing on ensuring support coordinator understanding of proper identification and assessment of new or previously unidentified risks; how to properly document changes in status including relevant follow-up; how to identify deficiencies or discrepancies in support plan or its implementation; and best practices for how to address and mitigate risks incorporating individual's strengths and preferences with support of planning team.<br><br>HSAG recommends DBHDS continue to define and communicate best practice expectations to CSBs for identifying, documenting, and addressing changes in status by support coordinators, including how to recognize change in status that occurs over time, when a new assessment may be indicated, and/or when intervention or action is most appropriate or required to address the change. |
| The ISP was developed according to the processes required. | **Statewide**: 31%<br>**Regions with opportunity**: 1, 2, 3, 4, 5<br>**Service types with opportunity**: ADR, CCO, CEN, GDY, GHC, GRS, GRL, ILS, IHS, SPR, SUL<br>**Recommendation:** HSAG recommends CSBs ensure support coordinator understanding of required processes for ISP development, specifically timely and accurate completion of RAT in conjunction with ISP, timely and accurate completion of VIDES in conjunction with ISP, and ISP development that includes coordination and input from the individual, their family/caregiver as appropriate, and all others as desired by the individual.<br><br>HSAG recommends DBHDS ensure CSBs have knowledge of and access to the most current training materials detailing best practices for ISP development processes, specifically accurate and timely completion of new RAT that reflects current risks addressed in person's ISP, timely and accurate completion of VIDES, and incorporation of input from all relevant |

| Element | Opportunity for Improvement |
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| | parties, including the individual and their family/caregiver. |
| Does the agency have a QI program policy and procedure? | **Statewide**: 59%<br>**Regions with opportunity**: *<br>**Service types with opportunity**: **<br>**Recommendation**: HSAG recommends that licensed providers/CSBs develop a Quality Improvement (QI) program policy and/or procedure, distinct from the provider's QI plan, that includes all aspects of 12VAC35-105-170, specifically how providers track community inclusion for individuals receiving services, how the provider determines if its personnel promote meaningful work and participation in non-large group activities, and how personnel encourage participation in community outings with people other than those with whom they live.<br><br>HSAG recommends DBHDS develop provider best practices and training curriculum specific to the tracking of community inclusion within a QI program policy and procedure sufficient for providers of all service types to utilize or utilize current curriculum with this content for targeted trainings (CSB, regional, and/or licensed provider specific). |
| Is the QI plan thorough? | **Statewide**: 53%<br>**Regions with opportunity**: *<br>**Service types with opportunity**: **<br>**Recommendation**: HSAG recommends that licensed providers/CSBs ensure the QI plan contains all aspects of 12VAC35-105-170 and 12VAC35-105-620A-E, including how the provider plans to and/or is addressing any findings born out of the execution of the QI Program Policy and Procedure related to provider tracking of community inclusion for individuals receiving services, including appropriate implementation of the process to track community inclusion, outcome of that process, and remediation steps to address any findings.<br><br>HSAG recommends DBHDS develop provider training specific to the tracking of community inclusion within a QI program policy and procedure sufficient for providers of all service types to utilize or utilize the current curriculum with this content for |

| Element | Opportunity for Improvement |
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| | targeted trainings (CSB, regional, and/or licensed provider specific). |
| Is the QI plan complete? | **Statewide**: 72%<br>**Regions with opportunity**: *<br>**Service types with opportunity**: **<br>**Recommendation**: HSAG recommends that licensed providers/CSBs ensure the QI plan includes all aspects of 12VAC35-105-620 A-E, including design and scope, governance and leadership, data systems and monitoring of feedback, performance improvement projects, systematic analysis, and systemic actions, and input from individual receiving services and their authorized representatives, if applicable, about services used and satisfaction level of participation in the direction of service planning. HSAG recommends that licensed providers/CSBs utilize the most current DBHDS published resources and trainings to guide plan development and/or revision.<br><br>HSAG recommends DBHDS identify key sources of licensed provider and/or CSB specific variability related to deficiencies in QI plans through root cause or other systemic analysis to better identify statewide patterns specific to QI plan standards for completeness not being met. |
| The quality improvement plan is reviewed annually. | **Statewide**: 76%<br>**Regions with opportunity**: *<br>**Service types with opportunity**: **<br>**Recommendation**: HSAG recommends that licensed providers/CSBs develop a process to conduct an annual review of their quality improvement plan, and document that process in accordance with Office of Licensing Guidance for a Quality Improvement Program, LIC 16, November 2020.<br><br>HSAG recommends DBHDS identify key sources of licensed provider and/or CSB specific variability related to annual review of QI plans through root cause analysis to better identify statewide patterns |

| Element | Opportunity for Improvement |
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| | specific to lack of annual review of QI plans by licensed providers/CSBs. |
| Licensed providers have active risk management and quality improvement programs. | **Statewide**: 74%<br>**Regions with opportunity**: *<br>**Service types with opportunity**: **<br>**Recommendation**: HSAG recommends that licensed providers/CSBs ensure their staff are actively involved in quality improvement and risk management activities and programs through participation in quarterly or annual review of QI/RM plans, or other risk efforts.<br><br>HSAG recommends DBHDS ensure licensed providers/CSBs have access to and knowledge of the most current DBHDS trainings that explicate expectations and suggested best practices for inclusion of staff in QI/RM activities. |
| Are HCBS policies and procedures reviewed with the individuals being served? | **Statewide**: 88%<br>**Regions with opportunity**: *<br>**Service types with opportunity**: **<br>**Recommendation**: HSAG recommends that licensed providers ensure HCBS policies include procedures for review with the individuals they serve to ensure completion upon admission to agency service and annually thereafter, and document when the policy is reviewed.<br><br>HSAG recommends DBHDS establish and communicate best practice expectations for implementation of HCBS settings rules for CSBs that do not provide services other than case management. |
| Does the agency have policies around the assurance of individual choice and self-determination? | **Statewide**: 76%<br>**Regions with opportunity**: *<br>**Service types with opportunity**: **<br>**Recommendation**: HSAG recommends that licensed providers/CSBs develop policies that address assurance of individual choice and self-determination, or policies that address the staff's role in supported decision-making and ensure staff understanding of concepts and how they apply to the individuals being served. |

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| | HSAG recommends DBHDS develop provider training specific to assurance of individual choice and self-determination which includes how to properly document staff role in supported decision-making for providers to implement or utilize current curriculum with this content for targeted trainings (CSB, regional, and/or licensed provider specific). |
| Does the agency have policies around the dignity of risk? | **Statewide**: 69%<br>**Regions with opportunity**: *<br>**Service types with opportunity**: **<br>**Recommendation**: HSAG recommends that licensed providers develop a policy that addresses the dignity of risk, including the rights of a person to make an informed choice, and the rights of the person to engage in experiences meaningful to him/her that is necessary for personal growth and development.<br>HSAG recommends that licensed providers/CSBs utilize DBHDS published resources and trainings to guide policy development and/or revision.<br><br>HSAG recommends DBHDS continue to develop and/or disseminate trainings with curriculum specific to dignity of risk and individual choice and determination to ensure licensed providers/CSBs have a working understanding of the concept and how to apply it to the individuals they serve. |
| Does the agency have policies around medical and behavioral health emergencies? | **Statewide**: 81%<br>**Regions with opportunity**: *<br>**Service types with opportunity**: **<br>**Recommendation**: HSAG recommends that licensed providers develop a policy and/or procedure(s) for staff to follow when medical and behavioral emergencies occur.<br><br>HSAG recommends DBHDS develop guidelines that detail best practice response to behavioral health emergencies or utilize current DBHDS curriculum with this content for targeted training (CSB, regional or licensed provider specific based on needs of individuals served.) |

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| Does the agency have policies that support individual' participation in financial management and decision-making? | **Statewide**: 71%<br>**Regions with opportunity**: *<br>**Service types with opportunity**: **<br>**Recommendation**: HSAG recommends that licensed providers of residential services develop a policy, procedure, or written process that outlines how they support individual participation in financial decision making.<br><br>HSAG recommends DBHDS continue to develop and/or disseminate trainings with curriculum specific to individuals' participation in financial decision-making to ensure licensed providers/CSBs have a working understanding of the concept, how to develop polices for the individuals they serve. |
| Does the agency have documentation of a signed lease, residency agreement, or other written agreement in place that provides language referencing individual protections from eviction for all persons served? | **Statewide**: 75%<br>**Regions with opportunity**: *<br>**Service types with opportunity**: **<br>**Recommendation**: HSAG recommends licensed providers of residential services develop a lease, residency agreement, or other written agreement that includes eviction protection, specifically regulation VRLTA § 55-248.16.<br><br>HSAG recommends DBHDS identify key sources of licensed provider and/or CSB specific variability related to lack of lease or residency agreement that includes individual protections from eviction to better identify statewide patterns and provide immediate remediation for individuals without current eviction protection for their residential supports. |
| Does the agency have a Risk Management Plan? | **Statewide**: 84%<br>**Regions with opportunity**: *<br>**Service types with opportunity**: **<br>**Recommendation**: HSAG recommends licensed providers develop a written risk management plan that includes all aspects of 12VAC35-105-520(B), specifically one designed to identify, monitor, reduce, and minimize harm and risk of harm which includes risks related to *personal injury*, *infectious disease,* |

| Element | Opportunity for Improvement |
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| | *property damage or loss,* and any sources of potential liability specific to the individuals they serve or services provided.<br><br>HSAG recommends DBHDS identify key sources of licensed provider and/or CSB specific variability related to deficiencies in RM plans through root cause or other systemic analysis to better identify statewide patterns specific to RM plan standards not being met. HSAG recommends DBHDS analyze qualitative QSR data collected during licensed provider and/or CSB PQR interviews who have deficient findings related to RM plans. |
| Is there documentation of a systemic review conducted annually of the Risk Management plan and a quarterly review of serious incidents? | **Statewide**: 78%<br>**Regions with opportunity**: *<br>**Service types with opportunity**: **<br>**Recommendation**: HSAG recommends licensed providers ensure a systemic review of risk management plan is conducted per 12VAC35-105-520(C) at least annually to identify and respond to practices or situations that could result in the risk of harm to individuals receiving services that address at a minimum the environment of care; clinical assessment or reassessment processes; staff competency and adequacy of staffing; use of high-risk procedures including seclusion and restraint; and review of serious incidents at least quarterly.<br><br>HSAG recommends DBHDS identify key sources of licensed provider and/or CSB specific variability related to lack of annual systemic review of the licensed providers/CSBs RM plan and/or lack of quarterly review of incidents through root cause or other systemic analysis to better identify statewide patterns specific to standards not being met. |
| Is the Risk Management plan thorough? | **Statewide**: 71%<br>**Regions with opportunity**: *<br>**Service types with opportunity**: **<br>**Recommendation**: HSAG recommends that licensed providers ensure the RM plan contains all aspects of 12VAC35-105-520(D)- 520 (F) |

| Element | Opportunity for Improvement |
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| | HSAG recommends DBHDS develop provider best practices and training curriculum specific to the development of a thorough risk management plan sufficient for providers of all service types to utilize or utilize current curriculum with this content for targeted training.<br><br>HSAG recommends DBHDS identify key sources of licensed provider and/or CSB specific variability related to lack of thorough RM plan better identify statewide patterns specific to standards not being met. |
| The licensed provider implements risk management processes, including the establishment of uniform risk triggers and thresholds, that enable them to adequately address harms and risks of harm. | **Statewide**: 83%<br>**Regions with opportunity**: *<br>**Service types with opportunity**: **<br>**Recommendation**: HSAG recommends that licensed providers increase efforts to implement Risk Management processes that contain all required aspects per DBHDS requirements, specifically the establishment of uniform risk triggers and a system for tracking those risk triggers and thresholds to better mitigate risks of harm. HSAG recommends that licensed providers utilize DBHDS published resources and trainings to guide process development and/or revision.<br><br>HSAG recommends DBHDS identify key sources of variance specific to licensed providers and/or CSBs inability to implement risk management processes that adequately address risks of harm through root cause analysis. |
| Reviewer confirms CHRIS incident report spreadsheet is free from patterns of abuse, neglect, or exploitation. | **Statewide**: 89%<br>**Regions with opportunity**: *<br>**Service types with opportunity**: **<br>**Recommendation**: HSAG recommends licensed providers/CSBs with identified patterns of abuse, neglect, and/or exploitation, complete the "*At A Glance Flow Chart for Incident Reviews*" developed by DBHDS to establish and/or build upon an internal incident review and mitigation process, including reports of abuse, neglect and exploitation. |

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| | HSAG recommends DBHDS continue to refine and communicate best practice expectations for appropriate response by licensed providers/CSBs to founded allegations of abuse, neglect, or exploitation and continue to communicate expectations for incorporation of those findings into provider quality improvement and/or risk management plans, policies, and processes through dissemination of statewide trainings that assist licensed providers/CSBs to complete the "*At A Glance Flow Chart for Incident Reviews*" developed by DBHDS to establish and/or build upon an internal incident review and mitigation process, including reports of abuse, neglect and exploitation. |
| Has the provider made progress on the actions identified in the QSR QIP? | **Statewide**: 64%<br>**Regions with opportunity**: *<br>**Service types with opportunity**: **<br>**Recommendation**: HSAG recommends licensed providers/CSBs incorporate QSR findings into current QI/RM processes.<br><br>HSAG recommends DBHDS continue to communicate expectations for licensed providers/CSBs to incorporate findings from QSR into systemic risk management and/or quality improvement activities. |
| Is there evidence of completion of an annual physical exam? | **Statewide**: 76%<br>**Regions with opportunity**: 1, 2, 3, 4, 5<br>**Service types with opportunity**: CCO, CEN, GDY, GHC, GRL, GRS, ILS, IHS. SPR, SUL<br>**Recommendation:** HSAG recommends that CSBs ensure all support coordinators discuss completion of annual physical exam during ISP planning and facilitate a physical exam with individual and all relevant parties, at minimum, annually; OR ensure any risks secondary to lack of physical exam are mitigated in ISP as appropriate.<br><br>HSAG recommends that licensed providers who are assigned this outcome in Part II ensure active facilitation of annual physical exams OR note |

| Element | Opportunity for Improvement |
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| | mitigation of potential risks secondary to lack of dental exam in Part V Plan for Supports. HSAG recommends that licensed providers who are assigned to this outcome in Part III of the ISP are aware of and document appropriately any health risks which require increased monitoring due to the lack of annual physical exams.<br><br>HSAG recommends DBHDS develop and communicate to CSBs best practice expectations for ensuring completion of an annual physical exam in addition to best practice expectations for mitigation of health risks secondary to lack of appropriate physical exams when completion of this assessment is declined by the individual and/or their designated representative. HSAG recommends DBHDS develop strategies for CSB staff to utilize during ISP planning when the individual and/or their representative are resistant to the completion of an annual physical exam. |
| Is there evidence of completion of an annual dental exam? | **Statewide**: 61%<br>**Regions with opportunity**: 1, 2, 3, 4, 5<br>**Service types with opportunity**: ADR, CCO, CEN, GDY, GHC, GRL, GRS, ILS, IHS, SPR, SUL<br>**Recommendation**: HSAG recommends that CSBs ensure all support coordinators discuss dental care during ISP planning and facilitate a dental exam with individual and all relevant parties, at minimum, annually; OR ensure any risks secondary to lack of dental exam are mitigated in ISP as appropriate.<br><br>HSAG recommends that licensed providers who are assigned this outcome in Part II ensure active facilitation of annual dental exams OR note mitigation of potential risks secondary to lack of dental exam in Part V Plan for Supports. HSAG recommends that licensed providers who are assigned to this outcome in Part III of the ISP are aware of and document appropriately any health risks which require increased monitoring due to the lack of annual dental exams.<br><br>HSAG recommends DBHDS ensure CSB knowledge and utilization of state resources designated to |

| Element | Opportunity for Improvement |
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| | improve dental hygiene for individuals, specifically individuals with documented health and/or behavioral barriers to obtaining appropriate dental care. HSAG recommends DBHDS develop and communicate to CSBs best practice expectations for ensuring completion of an annual dental exam in addition to best practice expectations for mitigation of health risks secondary to lack of appropriate dental exam when completion of this assessment is declined by individual and/or their designated representative.<br>HSAG recommends DBHDS develop strategies for CSB staff to utilize during ISP planning when the individual and/or their representative are resistant to the completion of an annual physical exam. |
| Does the agency have a hiring policy and procedure? | **Statewide**: 79%<br>**Regions with opportunity**: *<br>**Service types with opportunity**: **<br>**Recommendation**: HSAG recommends that licensed providers/CSBs understand DBHDS expectations for development of a policy and procedure specific to hiring staff.<br><br>HSAG recommends DBHDS develop and communicate best practice expectations for licensed providers/CSBs hiring policies and procedures that are congruent with DBHDS staffing initiatives. |
| Does the agency have an orientation training policy for all staff at all levels? | **Statewide**: 79%<br>**Regions with opportunity**: *<br>**Service types with opportunity**: **<br>**Recommendation**: HSAG recommends that licensed providers/CSBs ensure current orientation training policy includes all staff levels, or that providers develop an orientation training policy that includes all staff levels.<br><br>HSAG recommends DBHDS develop and communicate best practice expectations for licensed providers/CSBs orientation training that is appropriate for all staff levels. |

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| Does the agency have a process written for determining staff competence? | **Statewide**: 70%<br>**Regions with opportunity**: *<br>**Service types with opportunity**: **<br>**Recommendation**: HSAG recommends that licensed providers/CSBs develop processes for determining staff competence and document that process in written training policy, or other policy/procedure as appropriate.<br><br>HSAG recommends DBHDS develop training or utilize current DBHDS training with curriculum that defines staff competence and outlines best practice processes for determining staff competence. HSAG recommends DBHDS utilize trainings for targeted support to licensed providers/CSBs to ensure development of evidenced-based approaches and/or processes that determine licensed provider/CSB staff competence. HSAG recommends DBHDS clarify and communicate expectations for completion of advanced competencies, specifically requirements for individuals assigned to SIS® Level 5, Tier 4. |
| Does provider documentation show that the setting has implemented annual HCBS-specific training with all staff? | **Statewide**: 79%<br>**Regions with opportunity**: *<br>**Service types with opportunity**: **<br>**Recommendation**: HSAG recommends licensed providers ensure annual HCBS-specific training is conducted and documented for all staff.<br><br>HSAG recommends DBHDS establish and communicate best practice expectations for implementation of HCBS settings rules for CSBs that do not provide services other than case management. |
| Is there a record of the individual receiving and signing their HCBS rights disclosure on an annual basis? | **Statewide**: 80%<br>**Regions with opportunity**: 1, 2, 3, 4, 5<br>**Service types with opportunity**: CCO, CEN, GDY, GHC, GRL, GRS, ILS, IHS, SPR, SUL<br>**Recommendation**: HSAG recommends that licensed providers ensure HCBS policies are reviewed with and signed by the individuals they serve or their |

| Element | Opportunity for Improvement |
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| | representative upon admission to agency service and annually thereafter.<br><br>HSAG recommends DBHDS establish and communicate best practice expectations for implementation of HCBS settings rules for CSBs that do not provide services other than case management. |

**Region level tabulation of licensed provider PQR compliance results were not possible due to use of tax identification number (TIN) as the unique licensed provider identifier. For example, a single licensed provider could serve individuals across multiple regions, resulting in that licensed provider's compliance score being included in the aggregate score for multiple regions.*

***Licensed provider service type level tabulation of the licensed provider PQR compliance results were not possible due to the measurement of compliance by the licensed provider rather than their specific service type. For example, a single licensed provider's PQR compliance score could be attributed to more than one service type, resulting in the licensed provider's PQR compliance score being included in the aggregate score for more than one service type.*

*[1]These compliance elements were measured using scoring criteria that are inverse, meaning a lower percentage indicates better compliance. Compliance cut-off standards remained the same, hence compliance percentages greater than 10% indicate areas with opportunities for improvement.*

# Appendix A. CSB: ISP Assessment 1

Table 1 provides the CSB-specific compliance results for five of the ISP assessment elements.

**Table 1—CSB: Individual Support Plan (ISP) Assessment Compliance Elements 1**

| ISP Assessment Compliance Elements | | | | | |
|---|---|---|---|---|---|
| **CSB** | **Were any assessments completed after the initiation of the ISP and used to inform changes to the ISP?** | **Does the ISP incorporate high-risk health factors identified in the RAT?** | **Does the assessment include all information related to the person's ISP?** | **Is Part I of the ISP complete and thorough?** | **Does the ISP Part II include the individual's health and behavioral support needs?** |
| **All CSBs: Aggregate** | **48%** | **61%** | **66%** | **81%** | **70%** |
| ALEXANDRIA COMMUNITY SERV BD | 0% | 100% | 100% | 100% | 67% |
| ALLEGHANY HIGHLANDS CSB | - | 100% | 93% | 0% | 100% |
| ARLINGTON MENTAL HEALTH | 100% | 100% | 100% | 86% | 86% |
| BLUE RIDGE CSB | 38% | 21% | 28% | 78% | 39% |
| CHESAPEAKE INTERGRATED BEHAV HEALTHCARE | - | 73% | 85% | 77% | 85% |
| CHESTERFIELD CSB | 60% | 64% | 57% | 83% | 74% |
| CITY OF VA BEACH CSB MHMRSAS | 70% | 45% | 52% | 69% | 58% |
| COLONIAL BEHAVIORAL HEALTH | 0% | 100% | 83% | 67% | 83% |
| CROSSROADS CSB | - | 50% | 67% | 100% | 50% |
| DANVILLE-PITTSYLVANIA COM SERV | 50% | 64% | 63% | 83% | 63% |
| DICKENSON COUNTY BEHAVIORAL HEALTH SVCS | - | 100% | 100% | 100% | 100% |
| DISTRICT 19 MEN HLTH SER | 25% | 55% | 70% | 52% | 74% |
| EASTERN SHORE CSB | 0% | 50% | 56% | 50% | 94% |
| FAIRFAX-FALLS CHURCH CSB | 82% | 96% | 98% | 100% | 93% |

| ISP Assessment Compliance Elements | | | | | |
|---|---|---|---|---|---|
| **CSB** | **Were any assessments completed after the initiation of the ISP and used to inform changes to the ISP?** | **Does the ISP incorporate high-risk health factors identified in the RAT?** | **Does the assessment include all information related to the person's ISP?** | **Is Part I of the ISP complete and thorough?** | **Does the ISP Part II include the individual's health and behavioral support needs?** |
| GOOCHLAND POWHATAN MENTAL HLTH | 0% | 83% | 83% | 100% | 67% |
| HAMPTON-NN CSB | 40% | 55% | 85% | 88% | 81% |
| HANOVER COUNTY COMMUNITY SERVICES | - | 67% | 50% | 100% | 75% |
| HARRISONBURG-ROCKINGHAM CSB | 67% | 47% | 53% | 100% | 35% |
| HENRICO AREA MENTAL HLTH & DEVLPMNTL SVC | 50% | 46% | 59% | 91% | 80% |
| HIGHLANDS CMNTY SVCS BOARD | - | 100% | 0% | 50% | 50% |
| HORIZON BEHAVIORAL HEALTH | 11% | 58% | 46% | 71% | 49% |
| LOUDOUN COUNTY CSB | 20% | 29% | 38% | 81% | 38% |
| MIDDLE PENINSULA NORTHERN NECK CSB | 50% | 25% | 75% | 75% | 75% |
| MOUNT ROGERS CSB | 50% | 57% | 71% | 100% | 100% |
| NEW RIVER VALLEY COMMUNITY SERVICES | 100% | 100% | 83% | 92% | 75% |
| NORFOLK COMMUNITY SERVICES BOARD | 100% | 56% | 69% | 89% | 82% |
| NORTHWESTERN COMMUNITY SVCS | 0% | 29% | 39% | 94% | 39% |
| PIEDMONT COMMUNITY SERVICES | 0% | 42% | 57% | 71% | 50% |
| PLANNING DISTRICT ONE CSB | 100% | 75% | 100% | 100% | 100% |
| PORTSMOUTH DEPT OF BEHAVIORAL | 75% | 33% | 75% | 71% | 75% |
| PRINCE WILLIAM COUNTY CSB | 43% | 91% | 88% | 97% | 82% |

| ISP Assessment Compliance Elements | | | | | |
|---|---|---|---|---|---|
| **CSB** | **Were any assessments completed after the initiation of the ISP and used to inform changes to the ISP?** | **Does the ISP incorporate high-risk health factors identified in the RAT?** | **Does the assessment include all information related to the person's ISP?** | **Is Part I of the ISP complete and thorough?** | **Does the ISP Part II include the individual's health and behavioral support needs?** |
| RAPPAHANNOCK AREA COMMUNITY SERVICES BRD | 33% | 94% | 89% | 94% | 83% |
| RAPPAHANNOCK RAPIDAN CSB | 25% | 17% | 17% | 100% | 17% |
| REGION TEN CMMNTY SVCS BRD | 0% | 42% | 40% | 75% | 35% |
| RICHMOND BHVRL HLTH AUTHORITY | 75% | 63% | 75% | 97% | 84% |
| ROCKBRIDGE AREA COMMUNITY SVS BOARD | 100% | 67% | 67% | 67% | 33% |
| SOUTHSIDE CSB | - | 100% | 67% | 100% | 83% |
| VALLEY CSB | 50% | 64% | 77% | 86% | 68% |
| WESTERN TIDEWATER COMMUNITY SERVICES BOA | 50% | 53% | 48% | 52% | 62% |

"-" *symbol in any of the CBS tables demonstrates that the associated PCR(s) had N/A as a response for the element.*

# Appendix B. CSB: ISP Assessment 2

Table 2 provides the CSB-specific compliance results for four of the ISP assessment elements.

**Table 2—CSB: Individual Support Plan (ISP) Assessment Compliance Elements 2**

| ISP Assessment Compliance Elements | | | | |
|---|---|---|---|---|
| **CSB** | **Does the ISP Part II include medications?** | **Does the ISP Part II include the individual's physical and health conditions?** | **Does the ISP Part II include the individual's social, developmental, behavioral, and family history?** | **Does the ISP Part II include the individual's communication, assistive technology and modifications needs?** |
| **All CSBs: Aggregate** | **96%** | **78%** | **90%** | **91%** |
| ALEXANDRIA COMMUNITY SERV BD | 100% | 83% | 67% | 83% |
| ALLEGHANY HIGHLANDS CSB | 100% | 93% | 100% | 86% |
| ARLINGTON MENTAL HEALTH | 100% | 100% | 100% | 86% |
| BLUE RIDGE CSB | 100% | 56% | 83% | 83% |
| CHESAPEAKE INTERGRATED BEHAV HEALTHCARE | 100% | 100% | 92% | 100% |
| CHESTERFIELD CSB | 100% | 74% | 87% | 96% |
| CITY OF VA BEACH CSB MHMRSAS | 98% | 71% | 88% | 96% |
| COLONIAL BEHAVIORAL HEALTH | 100% | 100% | 100% | 100% |
| CROSSROADS CSB | 83% | 17% | 83% | 83% |
| DANVILLE-PITTSYLVANIA COM SERV | 100% | 80% | 91% | 89% |
| DICKENSON COUNTY BEHAVIORAL HEALTH SVCS | 100% | 100% | 100% | 100% |
| DISTRICT 19 MEN HLTH SER | 96% | 74% | 74% | 83% |
| EASTERN SHORE CSB | 100% | 94% | 56% | 94% |
| FAIRFAX-FALLS CHURCH CSB | 95% | 89% | 91% | 98% |
| GOOCHLAND POWHATAN MENTAL HLTH | 100% | 83% | 100% | 83% |
| HAMPTON-NN CSB | 92% | 96% | 96% | 100% |

| ISP Assessment Compliance Elements | | | | |
|---|---|---|---|---|
| **CSB** | **Does the ISP Part II include medications?** | **Does the ISP Part II include the individual's physical and health conditions?** | **Does the ISP Part II include the individual's social, developmental, behavioral, and family history?** | **Does the ISP Part II include the individual's communication, assistive technology and modifications needs?** |
| HANOVER COUNTY COMMUNITY SERVICES | 100% | 75% | 100% | 100% |
| HARRISONBURG-ROCKINGHAM CSB | 100% | 76% | 100% | 94% |
| HENRICO AREA MENTAL HLTH & DEVLPMNTL SVC | 98% | 75% | 95% | 91% |
| HIGHLANDS CMNTY SVCS BOARD | 100% | 100% | 100% | 100% |
| HORIZON BEHAVIORAL HEALTH | 90% | 63% | 85% | 76% |
| LOUDOUN COUNTY CSB | 100% | 38% | 88% | 75% |
| MIDDLE PENINSULA NORTHERN NECK CSB | 100% | 75% | 100% | 100% |
| MOUNT ROGERS CSB | 100% | 86% | 100% | 100% |
| NEW RIVER VALLEY COMMUNITY SERVICES | 100% | 92% | 100% | 100% |
| NORFOLK COMMUNITY SERVICES BOARD | 100% | 93% | 89% | 96% |
| NORTHWESTERN COMMUNITY SVCS | 88% | 50% | 89% | 83% |
| PIEDMONT COMMUNITY SERVICES | 100% | 57% | 93% | 86% |
| PLANNING DISTRICT ONE CSB | 100% | 100% | 100% | 100% |
| PORTSMOUTH DEPT OF BEHAVIORAL | 100% | 83% | 75% | 96% |
| PRINCE WILLIAM COUNTY CSB | 100% | 82% | 100% | 79% |
| RAPPAHANNOCK AREA COMMUNITY SERVICES BRD | 94% | 94% | 100% | 94% |
| RAPPAHANNOCK RAPIDAN CSB | 83% | 50% | 100% | 83% |
| REGION TEN CMMNTY SVCS BRD | 100% | 65% | 85% | 100% |
| RICHMOND BHVRL HLTH AUTHORITY | 97% | 81% | 100% | 97% |
| ROCKBRIDGE AREA COMMUNITY SVS BOARD | 100% | 33% | 100% | 100% |

| ISP Assessment Compliance Elements | | | | |
|---|---|---|---|---|
| **CSB** | **Does the ISP Part II include medications?** | **Does the ISP Part II include the individual's physical and health conditions?** | **Does the ISP Part II include the individual's social, developmental, behavioral, and family history?** | **Does the ISP Part II include the individual's communication, assistive technology and modifications needs?** |
| SOUTHSIDE CSB | 100% | 67% | 83% | 83% |
| VALLEY CSB | 55% | 82% | 95% | 95% |
| WESTERN TIDEWATER COMMUNITY SERVICES BOA | 100% | 90% | 90% | 90% |

# Appendix C. CSB: ISP Development & Implementation 1

Table 3 provides the CSB-specific compliance results for five of the ISP development and implementation elements.

**Table 3—CSB: ISP Development and Implementation Compliance Elements 1**

| ISP Development and Implementation Compliance Elements | | | | | |
|---|---|---|---|---|---|
| **CSB** | **The ISP for this review period is within 365 days of the previous ISP.** | **The ISP reviewed identified all medical needs found in the SIS or other relevant assessments.** | **The ISP reviewed identified all behavioral needs found in the SIS or other relevant assessments.** | **Was the RAT completed timely?** | **Are any additional assessments needed for conditions listed?[1]** |
| **All CSBs: Aggregate** | **99%** | **72%** | **69%** | **84%** | **37%** |
| ALEXANDRIA COMMUNITY SERV BD | 100% | 83% | 75% | 100% | 50% |
| ALLEGHANY HIGHLANDS CSB | 100% | 93% | 90% | 100% | - |
| ARLINGTON MENTAL HEALTH | 100% | 100% | 100% | 100% | 50% |
| BLUE RIDGE CSB | 93% | 6% | 27% | 56% | 22% |
| CHESAPEAKE INTERGRATED BEHAV HEALTHCARE | 100% | 80% | 58% | 77% | 83% |
| CHESTERFIELD CSB | 100% | 84% | 55% | 87% | 9% |
| CITY OF VA BEACH CSB MHMRSAS | 100% | 70% | 66% | 85% | 79% |
| COLONIAL BEHAVIORAL HEALTH | 100% | 80% | 80% | 83% | 33% |
| CROSSROADS CSB | 100% | 67% | 50% | 50% | 20% |
| DANVILLE-PITTSYLVANIA COM SERV | 97% | 75% | 60% | 71% | 71% |
| DICKENSON COUNTY BEHAVIORAL HEALTH SVCS | 100% | 100% | 100% | 100% | - |

| ISP Development and Implementation Compliance Elements | | | | | |
|---|---|---|---|---|---|
| **CSB** | **The ISP for this review period is within 365 days of the previous ISP.** | **The ISP reviewed identified all medical needs found in the SIS or other relevant assessments.** | **The ISP reviewed identified all behavioral needs found in the SIS or other relevant assessments.** | **Was the RAT completed timely?** | **Are any additional assessments needed for conditions listed?[1]** |
| DISTRICT 19 MEN HLTH SER | 100% | 59% | 28% | 78% | 0% |
| EASTERN SHORE CSB | 100% | 73% | 75% | 88% | 0% |
| FAIRFAX-FALLS CHURCH CSB | 92% | 91% | 100% | 100% | 12% |
| GOOCHLAND POWHATAN MENTAL HLTH | 100% | 83% | 83% | 100% | 50% |
| HAMPTON-NN CSB | 100% | 96% | 91% | 73% | 76% |
| HANOVER COUNTY COMMUNITY SERVICES | 100% | 50% | 75% | 100% | 50% |
| HARRISONBURG-ROCKINGHAM CSB | 100% | 80% | 70% | 94% | 56% |
| HENRICO AREA MENTAL HLTH & DEVLPMNTL SVC | 100% | 71% | 73% | 77% | 7% |
| HIGHLANDS CMNTY SVCS BOARD | 100% | 100% | 0% | 50% | 100% |
| HORIZON BEHAVIORAL HEALTH | 100% | 53% | 53% | 90% | 26% |
| LOUDOUN COUNTY CSB | 100% | 38% | 50% | 88% | 13% |
| MIDDLE PENINSULA NORTHERN NECK CSB | 75% | 75% | 75% | 75% | 0% |
| MOUNT ROGERS CSB | 100% | 57% | 71% | 100% | 17% |
| NEW RIVER VALLEY COMMUNITY SERVICES | 100% | 89% | 91% | 100% | 0% |
| NORFOLK COMMUNITY SERVICES BOARD | 100% | 81% | 68% | 73% | 58% |
| NORTHWESTERN COMMUNITY SVCS | 100% | 29% | 54% | 94% | 33% |

| ISP Development and Implementation Compliance Elements | | | | | |
|---|---|---|---|---|---|
| **CSB** | **The ISP for this review period is within 365 days of the previous ISP.** | **The ISP reviewed identified all medical needs found in the SIS or other relevant assessments.** | **The ISP reviewed identified all behavioral needs found in the SIS or other relevant assessments.** | **Was the RAT completed timely?** | **Are any additional assessments needed for conditions listed?[1]** |
| PIEDMONT COMMUNITY SERVICES | 100% | 67% | 50% | 93% | 22% |
| PLANNING DISTRICT ONE CSB | 100% | 75% | 100% | 100% | - |
| PORTSMOUTH DEPT OF BEHAVIORAL | 100% | 68% | 70% | 71% | 53% |
| PRINCE WILLIAM COUNTY CSB | 100% | 94% | 84% | 97% | 31% |
| RAPPAHANNOCK AREA COMMUNITY SERVICES BRD | 100% | 83% | 78% | 72% | 50% |
| RAPPAHANNOCK RAPIDAN CSB | 100% | 17% | 50% | 50% | 75% |
| REGION TEN CMMNTY SVCS BRD | 100% | 71% | 59% | 95% | 50% |
| RICHMOND BHVRL HLTH AUTHORITY | 94% | 82% | 79% | 91% | 50% |
| ROCKBRIDGE AREA COMMUNITY SVS BOARD | 100% | 67% | 67% | 67% | 0% |
| SOUTHSIDE CSB | 100% | 80% | 67% | 83% | 0% |
| VALLEY CSB | 100% | 67% | 79% | 91% | 42% |
| WESTERN TIDEWATER COMMUNITY SERVICES BOA | 100% | 72% | 71% | 71% | 64% |

[1]*These compliance elements were measured using scoring criteria that are inverse, meaning a lower percentage indicates better compliance. Compliance cut-off standards remained the same, hence compliance percentages greater than 10% indicate areas with opportunities for improvement.*

"-" *symbol in any of the CBS tables demonstrates that the associated PCR(s) had N/A as a response for the element.*

# Appendix D. CSB: ISP Development & Implementation 2

Table 4 provides the CSB-specific compliance results for four of the ISP development and implementation elements.

**Table 4—CSB: ISP Development and Implementation Compliance Elements 2**

| ISP Development and Implementation Compliance Elements | | | | |
|---|---|---|---|---|
| **CSB** | **Does the ISP Part II include the individual's employment status and assessment of barriers to employment?** | **Does the ISP Part II include the individual's meaningful day and community involvement status?** | **Did the individual have support from people during the development of the ISP that they wanted?** | **Are all risks identified in Part II of the ISP addressed under an outcome in Part III?** |
| **All CSBs: Aggregate** | **97%** | **98%** | **97%** | **73%** |
| ALEXANDRIA COMMUNITY SERV BD | 100% | 100% | 100% | 83% |
| ALLEGHANY HIGHLANDS CSB | 100% | 100% | 100% | 93% |
| ARLINGTON MENTAL HEALTH | 100% | 100% | 100% | 100% |
| BLUE RIDGE CSB | 94% | 89% | 94% | 39% |
| CHESAPEAKE INTERGRATED BEHAV HEALTHCARE | 100% | 100% | 100% | 85% |
| CHESTERFIELD CSB | 100% | 100% | 96% | 70% |
| CITY OF VA BEACH CSB MHMRSAS | 96% | 96% | 90% | 67% |
| COLONIAL BEHAVIORAL HEALTH | 100% | 100% | 100% | 67% |
| CROSSROADS CSB | 100% | 100% | 100% | 33% |
| DANVILLE-PITTSYLVANIA COM SERV | 100% | 100% | 94% | 71% |
| DICKENSON COUNTY BEHAVIORAL HEALTH SVCS | 100% | 100% | 100% | 100% |
| DISTRICT 19 MEN HLTH SER | 100% | 100% | 100% | 52% |
| EASTERN SHORE CSB | 100% | 94% | 100% | 69% |

| ISP Development and Implementation Compliance Elements | | | | |
|---|---|---|---|---|
| **CSB** | **Does the ISP Part II include the individual's employment status and assessment of barriers to employment?** | **Does the ISP Part II include the individual's meaningful day and community involvement status?** | **Did the individual have support from people during the development of the ISP that they wanted?** | **Are all risks identified in Part II of the ISP addressed under an outcome in Part III?** |
| FAIRFAX-FALLS CHURCH CSB | 100% | 100% | 100% | 91% |
| GOOCHLAND POWHATAN MENTAL HLTH | 83% | 100% | 83% | 83% |
| HAMPTON-NN CSB | 96% | 100% | 100% | 92% |
| HANOVER COUNTY COMMUNITY SERVICES | 100% | 100% | 100% | 100% |
| HARRISONBURG-ROCKINGHAM CSB | 100% | 100% | 100% | 65% |
| HENRICO AREA MENTAL HLTH & DEVLPMNTL SVC | 98% | 100% | 98% | 75% |
| HIGHLANDS CMNTY SVCS BOARD | 100% | 100% | 100% | 0% |
| HORIZON BEHAVIORAL HEALTH | 95% | 95% | 93% | 44% |
| LOUDOUN COUNTY CSB | 94% | 100% | 94% | 69% |
| MIDDLE PENINSULA NORTHERN NECK CSB | 75% | 75% | 100% | 50% |
| MOUNT ROGERS CSB | 100% | 100% | 100% | 86% |
| NEW RIVER VALLEY COMMUNITY SERVICES | 100% | 100% | 100% | 83% |
| NORFOLK COMMUNITY SERVICES BOARD | 98% | 100% | 98% | 69% |
| NORTHWESTERN COMMUNITY SVCS | 94% | 100% | 94% | 67% |
| PIEDMONT COMMUNITY SERVICES | 92% | 93% | 93% | 71% |
| PLANNING DISTRICT ONE CSB | 100% | 100% | 100% | 100% |

| ISP Development and Implementation Compliance Elements | | | | |
|---|---|---|---|---|
| **CSB** | **Does the ISP Part II include the individual's employment status and assessment of barriers to employment?** | **Does the ISP Part II include the individual's meaningful day and community involvement status?** | **Did the individual have support from people during the development of the ISP that they wanted?** | **Are all risks identified in Part II of the ISP addressed under an outcome in Part III?** |
| PORTSMOUTH DEPT OF BEHAVIORAL | 90% | 100% | 96% | 83% |
| PRINCE WILLIAM COUNTY CSB | 100% | 100% | 97% | 91% |
| RAPPAHANNOCK AREA COMMUNITY SERVICES BRD | 100% | 100% | 100% | 100% |
| RAPPAHANNOCK RAPIDAN CSB | 100% | 100% | 100% | 67% |
| REGION TEN CMMNTY SVCS BRD | 95% | 100% | 100% | 60% |
| RICHMOND BHVRL HLTH AUTHORITY | 97% | 97% | 100% | 69% |
| ROCKBRIDGE AREA COMMUNITY SVS BOARD | 100% | 100% | 100% | 67% |
| SOUTHSIDE CSB | 100% | 100% | 100% | 83% |
| VALLEY CSB | 86% | 100% | 100% | 64% |
| WESTERN TIDEWATER COMMUNITY SERVICES BOA | 100% | 95% | 100% | 86% |

# Appendix E. CSB: ISP Development & Implementation 3

Table 5 provides the CSB-specific compliance results for four of the ISP development and implementation elements.

**Table 5—CSB: ISP Development and Implementation Compliance Elements 3**

| ISP Development and Implementation Compliance Elements | | | | |
|---|---|---|---|---|
| **CSB** | **Outcomes are developed in the life area of Employment as appropriate.** | **Outcomes are developed in the life area of Integrated Community Involvement as appropriate.** | **Outcomes are developed in the life area of Community Living as appropriate.** | **Outcomes are developed in the life area of Safety & Security as appropriate.** |
| **All CSBs: Aggregate** | **81%** | **93%** | **96%** | **90%** |
| ALEXANDRIA COMMUNITY SERV BD | 100% | 67% | 100% | 75% |
| ALLEGHANY HIGHLANDS CSB | 100% | 100% | 100% | 100% |
| ARLINGTON MENTAL HEALTH | 100% | 100% | 100% | 100% |
| BLUE RIDGE CSB | 33% | 92% | 94% | 92% |
| CHESAPEAKE INTERGRATED BEHAV HEALTHCARE | 100% | 86% | 100% | 100% |
| CHESTERFIELD CSB | 71% | 88% | 100% | 95% |
| CITY OF VA BEACH CSB MHMRSAS | 75% | 88% | 98% | 90% |
| COLONIAL BEHAVIORAL HEALTH | 50% | 100% | 80% | 83% |
| CROSSROADS CSB | - | 100% | - | 100% |
| DANVILLE-PITTSYLVANIA COM SERV | 76% | 94% | 84% | 90% |
| DICKENSON COUNTY BEHAVIORAL HEALTH SVCS | 100% | 100% | 100% | 100% |
| DISTRICT 19 MEN HLTH SER | 75% | 100% | 93% | 100% |
| EASTERN SHORE CSB | 100% | 100% | 100% | 100% |
| FAIRFAX-FALLS CHURCH CSB | 96% | 94% | 95% | 95% |

| ISP Development and Implementation Compliance Elements | | | | |
|---|---|---|---|---|
| **CSB** | **Outcomes are developed in the life area of Employment as appropriate.** | **Outcomes are developed in the life area of Integrated Community Involvement as appropriate.** | **Outcomes are developed in the life area of Community Living as appropriate.** | **Outcomes are developed in the life area of Safety & Security as appropriate.** |
| GOOCHLAND POWHATAN MENTAL HLTH | 100% | 100% | 100% | 100% |
| HAMPTON-NN CSB | 75% | 100% | 100% | 100% |
| HANOVER COUNTY COMMUNITY SERVICES | 100% | 100% | 100% | 75% |
| HARRISONBURG-ROCKINGHAM CSB | 100% | 75% | 100% | 71% |
| HENRICO AREA MENTAL HLTH & DEVLPMNTL SVC | 82% | 96% | 100% | 97% |
| HIGHLANDS CMNTY SVCS BOARD | 100% | 100% | 100% | 100% |
| HORIZON BEHAVIORAL HEALTH | 92% | 94% | 100% | 94% |
| LOUDOUN COUNTY CSB | 67% | 100% | 85% | 69% |
| MIDDLE PENINSULA NORTHERN NECK CSB | 67% | 100% | 100% | 50% |
| MOUNT ROGERS CSB | 100% | 100% | 100% | 100% |
| NEW RIVER VALLEY COMMUNITY SERVICES | 100% | 100% | 100% | 100% |
| NORFOLK COMMUNITY SERVICES BOARD | 50% | 87% | 94% | 89% |
| NORTHWESTERN COMMUNITY SVCS | 89% | 94% | 100% | 82% |
| PIEDMONT COMMUNITY SERVICES | - | 100% | 100% | 91% |
| PLANNING DISTRICT ONE CSB | 100% | 100% | 100% | 100% |
| PORTSMOUTH DEPT OF BEHAVIORAL | 75% | 100% | 100% | 100% |

| ISP Development and Implementation Compliance Elements | | | | |
|---|---|---|---|---|
| **CSB** | **Outcomes are developed in the life area of Employment as appropriate.** | **Outcomes are developed in the life area of Integrated Community Involvement as appropriate.** | **Outcomes are developed in the life area of Community Living as appropriate.** | **Outcomes are developed in the life area of Safety & Security as appropriate.** |
| PRINCE WILLIAM COUNTY CSB | 85% | 95% | 91% | 92% |
| RAPPAHANNOCK AREA COMMUNITY SERVICES BRD | 100% | 100% | 100% | 90% |
| RAPPAHANNOCK RAPIDAN CSB | - | 100% | 100% | 100% |
| REGION TEN CMMNTY SVCS BRD | 40% | 67% | 88% | 38% |
| RICHMOND BHVRL HLTH AUTHORITY | 84% | 85% | 97% | 79% |
| ROCKBRIDGE AREA COMMUNITY SVS BOARD | 100% | 100% | 100% | 100% |
| SOUTHSIDE CSB | 100% | 100% | 100% | 100% |
| VALLEY CSB | 100% | 100% | 87% | 67% |
| WESTERN TIDEWATER COMMUNITY SERVICES BOA | 71% | 92% | 100% | 95% |

"-" *symbol in any of the CBS tables demonstrates that the associated PCR(s)had N/A as a response for the element.*

# Appendix F. CSB: ISP Development & Implementation 4

Table 6 provides the CSB-specific compliance results for four of the ISP development and implementation elements.

**Table 6—CSB: ISP Development and Implementation Compliance Elements 4**

| ISP Development and Implementation Compliance Elements | | | | |
|---|---|---|---|---|
| **CSB** | **Outcomes are developed in the life area of Healthy Living as appropriate.** | **Outcomes are developed in the life area of Social & Spirituality as appropriate.** | **Outcomes are developed in the life area of Citizenship & Advocacy as appropriate.** | **Are all needs in Part II assigned to Part III Outcome, including responsible provider?** |
| **All CSBs: Aggregate** | **95%** | **84%** | **95%** | **83%** |
| ALEXANDRIA COMMUNITY SERV BD | 83% | 100% | 100% | 100% |
| ALLEGHANY HIGHLANDS CSB | 100% | 100% | 100% | 93% |
| ARLINGTON MENTAL HEALTH | 100% | 75% | 100% | 100% |
| BLUE RIDGE CSB | 94% | 89% | 100% | 61% |
| CHESAPEAKE INTERGRATED BEHAV HEALTHCARE | 100% | 80% | 100% | 100% |
| CHESTERFIELD CSB | 95% | 87% | 93% | 83% |
| CITY OF VA BEACH CSB MHMRSAS | 87% | 81% | 98% | 62% |
| COLONIAL BEHAVIORAL HEALTH | 100% | 100% | 100% | 83% |
| CROSSROADS CSB | 100% | 75% | 100% | 83% |
| DANVILLE-PITTSYLVANIA COM SERV | 100% | 79% | 90% | 89% |
| DICKENSON COUNTY BEHAVIORAL HEALTH SVCS | 100% | 100% | 100% | 100% |
| DISTRICT 19 MEN HLTH SER | 93% | 86% | 93% | 70% |
| EASTERN SHORE CSB | 88% | 100% | 100% | 81% |
| FAIRFAX-FALLS CHURCH CSB | 98% | 76% | 80% | 87% |

| ISP Development and Implementation Compliance Elements | | | | |
|---|---|---|---|---|
| **CSB** | **Outcomes are developed in the life area of Healthy Living as appropriate.** | **Outcomes are developed in the life area of Social & Spirituality as appropriate.** | **Outcomes are developed in the life area of Citizenship & Advocacy as appropriate.** | **Are all needs in Part II assigned to Part III Outcome, including responsible provider?** |
| GOOCHLAND POWHATAN MENTAL HLTH | 100% | 100% | 100% | 100% |
| HAMPTON-NN CSB | 100% | 100% | 100% | 96% |
| HANOVER COUNTY COMMUNITY SERVICES | 100% | 100% | 100% | 100% |
| HARRISONBURG-ROCKINGHAM CSB | 88% | 50% | 94% | 100% |
| HENRICO AREA MENTAL HLTH & DEVLPMNTL SVC | 100% | 100% | 100% | 73% |
| HIGHLANDS CMNTY SVCS BOARD | 100% | 100% | 100% | 100% |
| HORIZON BEHAVIORAL HEALTH | 92% | 93% | 92% | 73% |
| LOUDOUN COUNTY CSB | 93% | 67% | 100% | 75% |
| MIDDLE PENINSULA NORTHERN NECK CSB | 100% | 100% | 50% | 50% |
| MOUNT ROGERS CSB | 100% | 100% | 100% | 86% |
| NEW RIVER VALLEY COMMUNITY SERVICES | 82% | 88% | 100% | 83% |
| NORFOLK COMMUNITY SERVICES BOARD | 91% | 92% | 98% | 84% |
| NORTHWESTERN COMMUNITY SVCS | 100% | 63% | 100% | 83% |
| PIEDMONT COMMUNITY SERVICES | 100% | 100% | 100% | 93% |
| PLANNING DISTRICT ONE CSB | 100% | 100% | 100% | 100% |
| PORTSMOUTH DEPT OF BEHAVIORAL | 100% | 88% | 100% | 92% |

| ISP Development and Implementation Compliance Elements | | | | |
|---|---|---|---|---|
| **CSB** | **Outcomes are developed in the life area of Healthy Living as appropriate.** | **Outcomes are developed in the life area of Social & Spirituality as appropriate.** | **Outcomes are developed in the life area of Citizenship & Advocacy as appropriate.** | **Are all needs in Part II assigned to Part III Outcome, including responsible provider?** |
| PRINCE WILLIAM COUNTY CSB | 100% | 88% | 91% | 100% |
| RAPPAHANNOCK AREA COMMUNITY SERVICES BRD | 100% | 90% | 100% | 83% |
| RAPPAHANNOCK RAPIDAN CSB | 83% | 100% | 100% | 50% |
| REGION TEN CMMNTY SVCS BRD | 80% | 36% | 17% | 95% |
| RICHMOND BHVRL HLTH AUTHORITY | 94% | 92% | 94% | 81% |
| ROCKBRIDGE AREA COMMUNITY SVS BOARD | 100% | 100% | 100% | 67% |
| SOUTHSIDE CSB | 100% | 100% | 100% | 67% |
| VALLEY CSB | 100% | 54% | 89% | 91% |
| WESTERN TIDEWATER COMMUNITY SERVICES BOA | 95% | 90% | 100% | 95% |

# Appendix G. CSB: ISP Development & Implementation 5

Table 7 provides the CSB-specific compliance results for four of the ISP development and implementation elements.

**Table 7—CSB: ISP Development and Implementation Compliance Elements 5**

| ISP Development and Implementation Compliance Elements | | | | |
|---|---|---|---|---|
| **CSB** | **Are all outcomes identified in Part III linked to Part V PFS as appropriate?** | **Does the ISP include strategies for solving conflict or disagreement that occurs during the ISP meeting with ISP supports, outcomes, or individual decisions?** | **The ISP and/or other SC documentation confirmed review of the ISP was conducted with the individual quarterly or every 90 days.** | **The ISP and/or other SC documentation supports that the individual was given a choice regarding services and supports, including the individual's residential setting, and who provides them.** |
| **All CSBs: Aggregate** | **89%** | **85%** | **73%** | **88%** |
| ALEXANDRIA COMMUNITY SERV BD | 100% | - | 75% | 100% |
| ALLEGHANY HIGHLANDS CSB | 86% | - | 100% | 100% |
| ARLINGTON MENTAL HEALTH | 86% | - | 86% | 100% |
| BLUE RIDGE CSB | 56% | 100% | 72% | 72% |
| CHESAPEAKE INTERGRATED BEHAV HEALTHCARE | 100% | - | 100% | 92% |
| CHESTERFIELD CSB | 91% | 100% | 74% | 70% |
| CITY OF VA BEACH CSB MHMRSAS | 90% | 50% | 83% | 87% |
| COLONIAL BEHAVIORAL HEALTH | 83% | 100% | 83% | 100% |
| CROSSROADS CSB | 83% | 100% | 100% | 83% |
| DANVILLE-PITTSYLVANIA COM SERV | 80% | 100% | 85% | 100% |

| ISP Development and Implementation Compliance Elements | | | | |
|---|---|---|---|---|
| **CSB** | **Are all outcomes identified in Part III linked to Part V PFS as appropriate?** | **Does the ISP include strategies for solving conflict or disagreement that occurs during the ISP meeting with ISP supports, outcomes, or individual decisions?** | **The ISP and/or other SC documentation confirmed review of the ISP was conducted with the individual quarterly or every 90 days.** | **The ISP and/or other SC documentation supports that the individual was given a choice regarding services and supports, including the individual's residential setting, and who provides them.** |
| DICKENSON COUNTY BEHAVIORAL HEALTH SVCS | 100% | - | 100% | 100% |
| DISTRICT 19 MEN HLTH SER | 83% | 100% | 32% | 61% |
| EASTERN SHORE CSB | 100% | - | 94% | 100% |
| FAIRFAX-FALLS CHURCH CSB | 98% | 33% | 72% | 98% |
| GOOCHLAND POWHATAN MENTAL HLTH | 100% | 100% | 100% | 100% |
| HAMPTON-NN CSB | 96% | 86% | 81% | 77% |
| HANOVER COUNTY COMMUNITY SERVICES | 100% | 100% | 75% | 100% |
| HARRISONBURG-ROCKINGHAM CSB | 100% | 50% | 88% | 94% |
| HENRICO AREA MENTAL HLTH & DEVLPMNTL SVC | 84% | 100% | 75% | 82% |
| HIGHLANDS CMNTY SVCS BOARD | 100% | - | 100% | 100% |
| HORIZON BEHAVIORAL HEALTH | 73% | 92% | 20% | 76% |
| LOUDOUN COUNTY CSB | 81% | 89% | 73% | 100% |
| MIDDLE PENINSULA NORTHERN NECK CSB | 75% | 100% | 100% | 100% |
| MOUNT ROGERS CSB | 71% | 100% | 86% | 100% |
| NEW RIVER VALLEY COMMUNITY SERVICES | 83% | - | 92% | 100% |

| ISP Development and Implementation Compliance Elements | | | | |
|---|---|---|---|---|
| **CSB** | **Are all outcomes identified in Part III linked to Part V PFS as appropriate?** | **Does the ISP include strategies for solving conflict or disagreement that occurs during the ISP meeting with ISP supports, outcomes, or individual decisions?** | **The ISP and/or other SC documentation confirmed review of the ISP was conducted with the individual quarterly or every 90 days.** | **The ISP and/or other SC documentation supports that the individual was given a choice regarding services and supports, including the individual's residential setting, and who provides them.** |
| NORFOLK COMMUNITY SERVICES BOARD | 98% | 100% | 91% | 89% |
| NORTHWESTERN COMMUNITY SVCS | 100% | 100% | 94% | 100% |
| PIEDMONT COMMUNITY SERVICES | 86% | 67% | 77% | 93% |
| PLANNING DISTRICT ONE CSB | 100% | - | 75% | 75% |
| PORTSMOUTH DEPT OF BEHAVIORAL | 100% | 100% | 63% | 100% |
| PRINCE WILLIAM COUNTY CSB | 97% | 56% | 61% | 100% |
| RAPPAHANNOCK AREA COMMUNITY SERVICES BRD | 89% | 60% | 44% | 100% |
| RAPPAHANNOCK RAPIDAN CSB | 67% | 100% | 50% | 67% |
| REGION TEN CMMNTY SVCS BRD | 95% | 100% | 75% | 100% |
| RICHMOND BHVRL HLTH AUTHORITY | 91% | 100% | 66% | 53% |
| ROCKBRIDGE AREA COMMUNITY SVS BOARD | 67% | - | 67% | 100% |
| SOUTHSIDE CSB | 50% | 100% | 100% | 83% |
| VALLEY CSB | 100% | 100% | 64% | 95% |
| WESTERN TIDEWATER COMMUNITY SERVICES BOA | 81% | 100% | 57% | 86% |

"-" *symbol in any of the CBS tables demonstrates that the associated PCR(s)had N/A as a response for the element.*

# Appendix H. CSB: ISP Development & Implementation 6

Table 8 provides the CSB-specific compliance results for three of the ISP development and implementation elements.

**Table 8—CSB: ISP Development and Implementation Compliance Elements 6**

| ISP Development and Implementation Compliance Elements | | | |
|---|---|---|---|
| **CSB** | **The ISP includes signatures of the individual (or representative) and all providers responsible for its implementation.** | **The ISP and/or the individual's file included documentation the support coordinator identified and resolved any unidentified or inadequately addressed risk, injury, need, or change in status, a deficiency in the individual's support plan or its implementation, or a discrepancy between the implementation of supports and services and the individual's strengths and preferences.** | **The ISP was developed according to the processes required.** |
| **All CSBs: Aggregate** | **93%** | **20%** | **31%** |
| ALEXANDRIA COMMUNITY SERV BD | 100% | 0% | 67% |
| ALLEGHANY HIGHLANDS CSB | 100% | 0% | 0% |
| ARLINGTON MENTAL HEALTH | 100% | - | 71% |
| BLUE RIDGE CSB | 72% | 33% | 6% |
| CHESAPEAKE INTERGRATED BEHAV HEALTHCARE | 100% | 29% | 46% |
| CHESTERFIELD CSB | 96% | 47% | 39% |
| CITY OF VA BEACH CSB MHMRSAS | 92% | 34% | 13% |
| COLONIAL BEHAVIORAL HEALTH | 67% | 20% | 83% |
| CROSSROADS CSB | 83% | 20% | 0% |
| DANVILLE-PITTSYLVANIA COM SERV | 89% | 11% | 17% |

| ISP Development and Implementation Compliance Elements | | | |
|---|---|---|---|
| **CSB** | **The ISP includes signatures of the individual (or representative) and all providers responsible for its implementation.** | **The ISP and/or the individual's file included documentation the support coordinator identified and resolved any unidentified or inadequately addressed risk, injury, need, or change in status, a deficiency in the individual's support plan or its implementation, or a discrepancy between the implementation of supports and services and the individual's strengths and preferences.** | **The ISP was developed according to the processes required.** |
| DICKENSON COUNTY BEHAVIORAL HEALTH SVCS | 100% | 0% | 100% |
| DISTRICT 19 MEN HLTH SER | 91% | 6% | 17% |
| EASTERN SHORE CSB | 100% | 25% | 38% |
| FAIRFAX-FALLS CHURCH CSB | 98% | 13% | 62% |
| GOOCHLAND POWHATAN MENTAL HLTH | 100% | 60% | 67% |
| HAMPTON-NN CSB | 96% | 6% | 42% |
| HANOVER COUNTY COMMUNITY SERVICES | 100% | 50% | 50% |
| HARRISONBURG-ROCKINGHAM CSB | 59% | 0% | 12% |
| HENRICO AREA MENTAL HLTH & DEVLPMNTL SVC | 98% | 18% | 16% |
| HIGHLANDS CMNTY SVCS BOARD | 100% | 0% | 0% |
| HORIZON BEHAVIORAL HEALTH | 90% | 0% | 17% |
| LOUDOUN COUNTY CSB | 100% | 0% | 19% |
| MIDDLE PENINSULA NORTHERN NECK CSB | 75% | 75% | 0% |
| MOUNT ROGERS CSB | 100% | 60% | 43% |
| NEW RIVER VALLEY COMMUNITY SERVICES | 92% | 67% | 50% |

| ISP Development and Implementation Compliance Elements | | | |
|---|---|---|---|
| **CSB** | **The ISP includes signatures of the individual (or representative) and all providers responsible for its implementation.** | **The ISP and/or the individual's file included documentation the support coordinator identified and resolved any unidentified or inadequately addressed risk, injury, need, or change in status, a deficiency in the individual's support plan or its implementation, or a discrepancy between the implementation of supports and services and the individual's strengths and preferences.** | **The ISP was developed according to the processes required.** |
| NORFOLK COMMUNITY SERVICES BOARD | 98% | 37% | 27% |
| NORTHWESTERN COMMUNITY SVCS | 72% | 7% | 11% |
| PIEDMONT COMMUNITY SERVICES | 86% | 33% | 36% |
| PLANNING DISTRICT ONE CSB | 75% | 0% | 25% |
| PORTSMOUTH DEPT OF BEHAVIORAL | 88% | 7% | 29% |
| PRINCE WILLIAM COUNTY CSB | 94% | 5% | 68% |
| RAPPAHANNOCK AREA COMMUNITY SERVICES BRD | 100% | 20% | 67% |
| RAPPAHANNOCK RAPIDAN CSB | 67% | 20% | 0% |
| REGION TEN CMMNTY SVCS BRD | 100% | 70% | 25% |
| RICHMOND BHVRL HLTH AUTHORITY | 100% | 28% | 31% |
| ROCKBRIDGE AREA COMMUNITY SVS BOARD | 100% | 33% | 33% |
| SOUTHSIDE CSB | 83% | 20% | 33% |
| VALLEY CSB | 100% | 12% | 27% |

| ISP Development and Implementation Compliance Elements | | | |
|---|---|---|---|
| **CSB** | **The ISP includes signatures of the individual (or representative) and all providers responsible for its implementation.** | **The ISP and/or the individual's file included documentation the support coordinator identified and resolved any unidentified or inadequately addressed risk, injury, need, or change in status, a deficiency in the individual's support plan or its implementation, or a discrepancy between the implementation of supports and services and the individual's strengths and preferences.** | **The ISP was developed according to the processes required.** |
| WESTERN TIDEWATER COMMUNITY SERVICES BOA | 95% | 5% | 24% |

"-" *symbol in any of the CBS tables demonstrates that the associated PCR(s)had N/A as a response for the element.*

# Appendix I. CSB: Risk/Harm

Table 9 provides the CSB-specific compliance results for the risk/harm elements.

**Table 9—CSB: Risk/Harm Compliance Elements**

| Risk/Harm Compliance Elements | | |
|---|---|---|
| **CSB** | **Is there evidence of completion of an annual physical exam?** | **Is there evidence of completion of an annual dental exam?** |
| **All CSBs: Aggregate** | **76%** | **61%** |
| ALEXANDRIA COMMUNITY SERV BD | 60% | 60% |
| ALLEGHANY HIGHLANDS CSB | 100% | 25% |
| ARLINGTON MENTAL HEALTH | 100% | 100% |
| BLUE RIDGE CSB | 86% | 43% |
| CHESAPEAKE INTERGRATED BEHAV HEALTHCARE | 91% | 82% |
| CHESTERFIELD CSB | 71% | 76% |
| CITY OF VA BEACH CSB MHMRSAS | 75% | 45% |
| COLONIAL BEHAVIORAL HEALTH | 75% | 25% |
| CROSSROADS CSB | 83% | 33% |
| DANVILLE-PITTSYLVANIA COM SERV | 56% | 59% |
| DICKENSON COUNTY BEHAVIORAL HEALTH SVCS | 50% | 50% |
| DISTRICT 19 MEN HLTH SER | 63% | 53% |
| EASTERN SHORE CSB | 100% | 80% |
| FAIRFAX-FALLS CHURCH CSB | 72% | 66% |
| GOOCHLAND POWHATAN MENTAL HLTH | 33% | 33% |
| HAMPTON-NN CSB | 88% | 68% |
| HANOVER COUNTY COMMUNITY SERVICES | 100% | 67% |
| HARRISONBURG-ROCKINGHAM CSB | 76% | 53% |
| HENRICO AREA MENTAL HLTH & DEVLPMNTL SVC | 71% | 76% |
| HIGHLANDS CMNTY SVCS BOARD | 50% | 100% |

| Risk/Harm Compliance Elements | | |
|---|---|---|
| **CSB** | **Is there evidence of completion of an annual physical exam?** | **Is there evidence of completion of an annual dental exam?** |
| HORIZON BEHAVIORAL HEALTH | 74% | 60% |
| LOUDOUN COUNTY CSB | 73% | 73% |
| MIDDLE PENINSULA NORTHERN NECK CSB | 67% | 33% |
| MOUNT ROGERS CSB | 100% | 80% |
| NEW RIVER VALLEY COMMUNITY SERVICES | 100% | 70% |
| NORFOLK COMMUNITY SERVICES BOARD | 70% | 42% |
| NORTHWESTERN COMMUNITY SVCS | 71% | 71% |
| PIEDMONT COMMUNITY SERVICES | 70% | 40% |
| PLANNING DISTRICT ONE CSB | 100% | 100% |
| PORTSMOUTH DEPT OF BEHAVIORAL | 81% | 52% |
| PRINCE WILLIAM COUNTY CSB | 83% | 77% |
| RAPPAHANNOCK AREA COMMUNITY SERVICES BRD | 69% | 54% |
| RAPPAHANNOCK RAPIDAN CSB | 100% | 33% |
| REGION TEN CMMNTY SVCS BRD | 79% | 71% |
| RICHMOND BHVRL HLTH AUTHORITY | 70% | 60% |
| ROCKBRIDGE AREA COMMUNITY SVS BOARD | 100% | 100% |
| SOUTHSIDE CSB | 100% | 83% |
| VALLEY CSB | 81% | 69% |
| WESTERN TIDEWATER COMMUNITY SERVICES BOA | 69% | 38% |

# Appendix J. Region: ISP Assessment

Tables 10 and 11 provide the region-specific compliance results for the ISP assessment elements.

**Table 10—Region: ISP Assessment Compliance Elements**

| ISP Assessment Compliance Elements | | | | | |
|---|---|---|---|---|---|
| **Region** | **Were any assessments completed after the initiation of the ISP and used to inform changes to the ISP?** | **Does the ISP incorporate high-risk health factors identified in the RAT?** | **Does the assessment include all information related to the person's ISP?** | **Is Part I of the ISP complete and thorough?** | **Does the ISP Part II include the individual's health and behavioral support needs?** |
| **All Regions: Aggregate** | **48%** | **61%** | **66%** | **81%** | **70%** |
| Region 1 | 23% | 58% | 58% | 77% | 54% |
| Region 2 | 56% | 85% | 86% | 95% | 80% |
| Region 3 | 48% | 62% | 60% | 84% | 64% |
| Region 4 | 54% | 57% | 65% | 86% | 77% |
| Region 5 | 61% | 52% | 66% | 73% | 74% |

**Table 11—Region: ISP Assessment Compliance Elements**

| ISP Assessment Compliance Elements | | | | |
|---|---|---|---|---|
| **Region** | **Does the ISP Part II include medications?** | **Does the ISP Part II include the individual's physical and health conditions?** | **Does the ISP Part II include the individual's social, developmental, behavioral, and family history?** | **Does the ISP Part II include the individual's communication, assistive technology and modifications needs?** |
| **All Regions: Aggregate** | **96%** | **78%** | **90%** | **91%** |
| Region 1 | 88% | 71% | 92% | 88% |
| Region 2 | 98% | 80% | 93% | 87% |
| Region 3 | 100% | 75% | 92% | 90% |
| Region 4 | 97% | 74% | 91% | 91% |
| Region 5 | 98% | 87% | 86% | 96% |

# Appendix K. Region: ISP Development & Implementation 1

Table 12 provides the region-specific compliance results for five of the ISP development and implementation elements.

**Table 12—Region: ISP Development and Implementation Compliance Elements 1**

| ISP Development and Implementation Compliance Elements | | | | | |
|---|---|---|---|---|---|
| **Region** | **The ISP for this review period is within 365 days of the previous ISP.** | **The ISP reviewed identified all medical needs found in the SIS or other relevant assessments.** | **The ISP reviewed identified all behavioral needs found in the SIS or other relevant assessments.** | **Was the RAT completed timely?** | **Are any additional assessments needed for conditions listed?[1]** |
| **All Regions: Aggregate** | **99%** | **72%** | **69%** | **84%** | **37%** |
| Region 1 | 100% | 63% | 65% | 89% | 39% |
| Region 2 | 97% | 84% | 88% | 97% | 21% |
| Region 3 | 98% | 61% | 59% | 79% | 28% |
| Region 4 | 98% | 73% | 63% | 83% | 15% |
| Region 5 | 99% | 77% | 71% | 77% | 64% |

[1] *These compliance elements were measured using scoring criteria that are inverse, meaning a lower percentage indicates better compliance. Compliance cut-off standards remained the same, hence compliance percentages greater than 10% indicate areas with opportunities for improvement.*

# Appendix L. Region: ISP Development & Implementation 2

Table 13 provides the region-specific compliance results for four of the ISP development and implementation elements.

**Table 13—Region: ISP Development and Implementation Compliance Elements 2**

| ISP Development and Implementation Compliance Elements | | | | |
|---|---|---|---|---|
| **Region** | **Does the ISP Part II include the individual's employment status and assessment of barriers to employment?** | **Does the ISP Part II include the individual's meaningful day and community involvement status?** | **Did the individual have support from people during the development of the ISP that they wanted?** | **Are all risks identified in Part II of the ISP addressed under an outcome in Part III?** |
| **All Regions: Aggregate** | **97%** | **98%** | **97%** | **73%** |
| Region 1 | 95% | 99% | 97% | 65% |
| Region 2 | 99% | 100% | 98% | 88% |
| Region 3 | 98% | 97% | 96% | 69% |
| Region 4 | 98% | 99% | 98% | 68% |
| Region 5 | 96% | 98% | 97% | 75% |

# Appendix M. Region: ISP Development & Implementation 3

Table 14 provides the region-specific compliance results for four of the ISP development and implementation elements.

**Table 14—Region: ISP Development and Implementation Compliance Elements 3**

| ISP Development and Implementation Compliance Elements | | | | |
|---|---|---|---|---|
| **Region** | **Outcomes are developed in the life area of Employment as appropriate.** | **Outcomes are developed in the life area of Integrated Community Involvement as appropriate.** | **Outcomes are developed in the life area of Community Living as appropriate.** | **Outcomes are developed in the life area of Safety & Security as appropriate.** |
| **All Regions: Aggregate** | **81%** | **93%** | **96%** | **90%** |
| Region 1 | 90% | 91% | 96% | 81% |
| Region 2 | 88% | 95% | 93% | 90% |
| Region 3 | 76% | 96% | 94% | 94% |
| Region 4 | 82% | 94% | 98% | 92% |
| Region 5 | 70% | 92% | 98% | 93% |

# Appendix N. Region: ISP Development & Implementation 4

Table 15 provides the region-specific compliance results for four of the ISP development and implementation elements.

**Table 15—Region: ISP Development and Implementation Compliance Elements 4**

| ISP Development and Implementation Compliance Elements | | | | |
|---|---|---|---|---|
| **Region** | **Outcomes are developed in the life area of Healthy Living as appropriate.** | **Outcomes are developed in the life area of Social & Spirituality as appropriate.** | **Outcomes are developed in the life area of Citizenship & Advocacy as appropriate.** | **Are all needs in Part II assigned to Part III Outcome, including responsible provider?** |
| **All Regions: Aggregate** | **95%** | **84%** | **95%** | **83%** |
| Region 1 | 94% | 68% | 88% | 84% |
| Region 2 | 97% | 78% | 90% | 91% |
| Region 3 | 97% | 90% | 99% | 83% |
| Region 4 | 97% | 92% | 96% | 78% |
| Region 5 | 93% | 90% | 98% | 82% |

# Appendix O. Region: ISP Development & Implementation 5

Table 16 provides the region-specific compliance results for four of the ISP development and implementation elements.

**Table 16—Region: ISP Development and Implementation Compliance Elements 5**

| ISP Development and Implementation Compliance Elements | | | | |
|---|---|---|---|---|
| **Region** | **Are all outcomes identified in Part III linked to Part V PFS as appropriate?** | **Does the ISP include strategies for solving conflict or disagreement that occurs during the ISP meeting with ISP supports, outcomes, or individual decisions?** | **The ISP and/or other SC documentation confirmed review of the ISP was conducted with the individual quarterly or every 90 days.** | **The ISP and/or other SC documentation supports that the individual was given a choice regarding services and supports, including the individual's residential setting, and who provides them.** |
| **All Regions: Aggregate** | **89%** | **85%** | **73%** | **88%** |
| Region 1 | 88% | 92% | 61% | 91% |
| Region 2 | 94% | 55% | 70% | 99% |
| Region 3 | 76% | 93% | 83% | 92% |
| Region 4 | 88% | 100% | 68% | 71% |
| Region 5 | 94% | 88% | 82% | 89% |

# Appendix P. Region: ISP Development & Implementation 6

Table 17 provides the region-specific compliance results for three of the ISP development and implementation elements.

**Table 17—Region: ISP Development and Implementation Compliance Elements 6**

| ISP Development and Implementation Compliance Elements | | | |
|---|---|---|---|
| **Region** | **The ISP includes signatures of the individual (or representative) and all providers responsible for its implementation.** | **The ISP and/or the individual's file included documentation the support coordinator identified and resolved any unidentified or inadequately addressed risk, injury, need, or change in status, a deficiency in the individual's support plan or its implementation, or a discrepancy between the implementation of supports and services and the individual's strengths and preferences.** | **The ISP was developed according to the processes required.** |
| **All Regions: Aggregate** | **93%** | **20%** | **31%** |
| Region 1 | 89% | 13% | 22% |
| Region 2 | 97% | 6% | 58% |
| Region 3 | 86% | 26% | 26% |
| Region 4 | 96% | 26% | 26% |
| Region 5 | 94% | 24% | 29% |

# Appendix Q. Region: Risk/Harm

Table 18 provides the region-specific compliance results for the risk/harm elements.

**Table 18—Region: Risk/Harm Compliance Elements**

| Risk/Harm Compliance Elements | | | |
|---|---|---|---|
| **Region** | **Is there evidence of completion of an annual physical exam?** | **Is there evidence of completion of an annual dental exam?** | **Is there an approved modification in place for health and safety risks OR is the individual in the process of requesting such approval?** |
| **All Regions: Aggregate** | **76%** | **61%** | **53%** |
| Region 1 | 78% | 60% | 62% |
| Region 2 | 77% | 73% | 28% |
| Region 3 | 76% | 61% | 63% |
| Region 4 | 70% | 65% | 80% |
| Region 5 | 79% | 53% | 44% |

# Appendix R. Region: Provider Capacity and Competency 1

Table 19 provides the region-specific compliance results for six of the provider capacity and competency elements.

**Table 19—Region: Provider Capacity and Competency 1**

| Provider Capacity and Competency | | | | | |
|---|---|---|---|---|---|
| **Region** | **Is there a record of the individual receiving and signing their HCBS rights disclosure on an annual basis?** | **Is the individual's/ provider's environment neat and clean?** | **Was the person's/ provider's environment accessible?** | **Were staff engaging with the individual based on the person's preference and interests?** | **Was the person being offered choices throughout the visit?** |
| **All Regions: Aggregate** | **80%** | **96%** | **99%** | **98%** | **98%** |
| Region 1 | 80% | 97% | 99% | 96% | 99% |
| Region 2 | 75% | 99% | 97% | 99% | 100% |
| Region 3 | 84% | 98% | 100% | 100% | 98% |
| Region 4 | 81% | 96% | 99% | 98% | 97% |
| Region 5 | 79% | 94% | 99% | 99% | 98% |

# Appendix S. Region: Provider Capacity and Competency 2

Table 20 provides the region-specific compliance results for five of the provider capacity and competency elements.

**Table 20—Region: Provider Capacity and Competency 2**

| Provider Capacity and Competency | | | | | |
|---|---|---|---|---|---|
| **Region** | **Were staff implementing the Part V as written?** | **For individuals with behavioral support plans were staff addressing behaviors per the written plan?** | **Were staff adhering to medical and behavioral protocols as outlined in the plan?** | **Were staff able to describe what community inclusion looks like for the individual?** | **Did the staff demonstrate competency in supporting the individual?** |
| **All Regions: Aggregate** | **98%** | **100%** | **99%** | **96%** | **100%** |
| Region 1 | 98% | 100% | 97% | 87% | 100% |
| Region 2 | 100% | 100% | 100% | 95% | 100% |
| Region 3 | 97% | 100% | 98% | 100% | 99% |
| Region 4 | 99% | 100% | 100% | 99% | 100% |
| Region 5 | 98% | 100% | 100% | 98% | 100% |

# Appendix T. Region: Provider Capacity and Competency 3

Table 21 provides the region-specific compliance results for five of the provider capacity and competency elements.

**Table 21—Region: Provider Capacity and Competency 3**

| Provider Capacity and Competency | | | | | |
|---|---|---|---|---|---|
| **Region** | **Are staff familiar with adaptive equipment needs?** | **Were staff utilizing adaptive equipment the individual had as part of their plan?** | **Are staff able to describe things important to and important for the individual?** | **Was staff able to describe the outcomes being worked on in this environment?** | **Could the staff describe the medical support needs of the individuals?** |
| **All Regions: Aggregate** | **97%** | **94%** | **98%** | **97%** | **95%** |
| Region 1 | 96% | 93% | 100% | 98% | 95% |
| Region 2 | 98% | 94% | 98% | 95% | 90% |
| Region 3 | 100% | 91% | 99% | 99% | 97% |
| Region 4 | 94% | 94% | 96% | 93% | 90% |
| Region 5 | 100% | 98% | 99% | 97% | 100% |

# Appendix U. Region: Provider Capacity and Competency 4

Table 22 provides the region-specific compliance results for six of the provider capacity and competency elements.

**Table 22—Region: Provider Capacity and Competency 4**

| Provider Capacity and Competency | | | | | | |
|---|---|---|---|---|---|---|
| **Region** | **Were staff familiar with medical protocols to support the person?** | **Could the staff describe behavioral support needs?** | **Were staff familiar with behavioral support plans or protocols developed to support the person?** | **Does the staff know what medications the person is taking or where to locate this information?** | **Can the staff list the most common side effects of the medications the person is on or where to locate that information?** | **Can you tell me what person-centered care means?** |
| **All Regions: Aggregate** | **95%** | **97%** | **95%** | **97%** | **94%** | **94%** |
| Region 1 | 95% | 99% | 99% | 95% | 94% | 95% |
| Region 2 | 95% | 98% | 95% | 98% | 93% | 98% |
| Region 3 | 100% | 97% | 96% | 97% | 92% | 94% |
| Region 4 | 82% | 94% | 90% | 98% | 92% | 89% |
| Region 5 | 100% | 97% | 96% | 99% | 97% | 96% |

Table 23 provides the region-specific compliance results for two of the provider capacity and competency elements.

**Table 23—Region: Provider Capacity and Competency 4**

| Provider Capacity and Competency | | | | |
|---|---|---|---|---|
| **Region** | **When were you last trained on Medication Administration?** | | **When were you last trained on Crisis Intervention?** | |
| | **>12 months** | **Never** | **>12 months** | **Never** |
| **All Regions: Aggregate** | **9.88%** | **5.55%** | **6.41%** | **1.39%** |
| Region 1 | 13.22% | 6.61% | 2.48% | 0.00% |
| Region 2 | 10.23% | 2.27% | 7.95% | 1.14% |
| Region 3 | 6.33% | 11.39% | 17.72% | 1.27% |
| Region 4 | 12.50% | 2.50% | 7.50% | 2.50% |
| Region 5 | 7.10% | 5.92% | 2.37% | 1.78% |

*Statewide, regional, and service type breakdown for compliance elements specific to training on medication administration and crisis intervention are offered for information only. DBHDS has not established a compliance threshold for these elements.*

# Appendix V. Service Type: ISP Assessment 1

Table 24 provides the provider service type-specific compliance results for five of the ISP assessment elements.

**Table 24—Service Type: ISP Assessment Compliance Elements 1**

| Individual Support Plan (ISP) Assessment Compliance Elements | | | | | |
|---|---|---|---|---|---|
| **Provider Service Type** | **Were any assessments completed after the initiation of the ISP and used to inform changes to the ISP?** | **Does the ISP incorporate high-risk health factors identified in the RAT?** | **Does the assessment include all information related to the person's ISP?** | **Is Part I of the ISP complete and thorough?** | **Does the ISP Part II include the individual's health and behavioral support needs?** |
| **All Service Type: Aggregate** | **43.98%** | **58.99%** | **63.78%** | **80.56%** | **66.08%** |
| Agency Directed Respite | 100% | 91.67% | 76.92% | 23.08% | 92.31% |
| Case Management | - | - | - | - | - |
| Community Coaching | 38.89% | 61.29% | 58.73% | 80.95% | 68.25% |
| Community Engagement | 40.00% | 55.88% | 64.94% | 79.22% | 57.14% |
| Group Day | 35.71% | 59.09% | 62.03% | 79.75% | 62.03% |
| Group Home (Customized Rate) | 52.94% | 64.00% | 74.51% | 80.39% | 66.67% |
| Group Residential Support <= 4 Persons | 61.54% | 61.97% | 73.75% | 82.50% | 78.75% |
| Group Residential Support > 4 Persons | 46.15% | 55.07% | 58.67% | 85.33% | 74.67% |
| Independent Living Supports | 44.44% | 71.11% | 79.63% | 88.89% | 79.63% |
| In-Home Supports | 30.77% | 63.77% | 70.13% | 87.01% | 70.13% |
| Sponsored Residential | 54.55% | 54.93% | 49.37% | 70.89% | 54.43% |
| Supported Living | 72.73% | 64.71% | 75.44% | 92.98% | 84.21% |

*"-"Indicates question N/A to service type.*

# Appendix W. Service Type: ISP Assessment 2

Table 25 provides the provider service type-specific compliance results for four of the ISP assessment elements.

**Table 25—Service Type: ISP Assessment Compliance Elements 2**

| Individual Support Plan (ISP) Assessment Compliance Elements | | | | |
|---|---|---|---|---|
| **Provider Service Type** | **Does the ISP Part II include medications?** | **Does the ISP Part II include the individual's physical and health conditions?** | **Does the ISP Part II include the individual's social, developmental, behavioral, and family history?** | **Does the ISP Part II include the individual's communication, assistive technology and modifications needs?** |
| **All Service Type: Aggregate** | **96.07%** | **75.28%** | **88.89%** | **90.95%** |
| Agency Directed Respite | 92.31% | 84.62% | 100% | 76.92% |
| Case Management | - | - | - | - |
| Community Coaching | 95.00% | 90.48% | 100% | 90.48% |
| Community Engagement | 97.26% | 77.92% | 90.91% | 90.91% |
| Group Day | 96.05% | 72.15% | 94.94% | 89.87% |
| Group Home (Customized Rate) | 98.04% | 70.59% | 94.12% | 92.16% |
| Group Residential Support <= 4 Persons | 96.20% | 77.50% | 81.25% | 91.25% |
| Group Residential Support > 4 Persons | 94.67% | 74.67% | 90.67% | 92.00% |
| Independent Living Supports | 97.96% | 87.04% | 96.30% | 92.59% |
| In-Home Supports | 95.83% | 84.42% | 83.12% | 90.91% |
| Sponsored Residential | 95.95% | 67.09% | 83.54% | 92.41% |
| Supported Living | 96.23% | 82.46% | 96.49% | 91.23% |

*"-"Indicates question N/A to service type.*

# Appendix X. Service Type: ISP Development & Implementation 1

Table 26 provides the provider service type-specific compliance results for five of the ISP development and implementation elements.

**Table 26—Service Type: ISP Development and Implementation Compliance Elements 1**

| ISP Development and Implementation Compliance Elements | | | | | |
|---|---|---|---|---|---|
| **Provider Service Type** | **The ISP for this review period is within 365 days of the previous ISP.** | **The ISP reviewed identified all medical needs found in the SIS or other relevant assessments.** | **The ISP reviewed identified all behavioral needs found in the SIS or other relevant assessments.** | **Was the RAT completed timely?** | **Are any additional assessments needed for conditions listed?[1]** |
| **All Service Type: Aggregate** | **99.21%** | **70.24%** | **67.16%** | **83.19%** | **41.09%** |
| Agency Directed Respite | 100% | 69.23% | 87.50% | 100% | - |
| Case Management | - | - | - | - | - |
| Community Coaching | 100% | 69.49% | 70.97% | 79.37% | 27.27% |
| Community Engagement | 97.14% | 66.67% | 69.84% | 75.32% | 38.71% |
| Group Day | 100% | 68.57% | 64.52% | 84.81% | 45.16% |
| Group Home (Customized Rate) | 98.00% | 73.91% | 72.00% | 80.39% | 29.63% |
| Group Residential Support <= 4 Persons | 100% | 72.22% | 80.28% | 81.25% | 44.44% |
| Group Residential Support > 4 Persons | 100% | 72.46% | 66.67% | 84.00% | 33.33% |
| Independent Living Supports | 100% | 81.82% | 83.87% | 88.89% | 26.67% |
| In-Home Supports | 98.48% | 73.91% | 60.66% | 89.61% | 59.26% |
| Sponsored Residential | 98.67% | 68.66% | 54.41% | 83.54% | 28.21% |
| Supported Living | 94.44% | 80.85% | 75.00% | 91.23% | 37.50% |

*[1]These compliance elements were measured using scoring criteria that are inverse, meaning a lower percentage indicates better compliance. Compliance cut-off standards remained the same, hence compliance percentages greater than 10% indicate areas with opportunities for improvement.*

*"-"Indicates question N/A to service type.*

# Appendix Y. Service Type: ISP Development & Implementation 2

Table 27 provides the provider service type-specific compliance results for four of the ISP development and implementation elements.

**Table 27—Service Type: ISP Development and Implementation Compliance Elements 2**

| ISP Development and Implementation Compliance Elements | | | | |
|---|---|---|---|---|
| **Provider Service Type** | **Does the ISP Part II include the individual's employment status and assessment of barriers to employment?** | **Does the ISP Part II include the individual's meaningful day and community involvement status?** | **Did the individual have support from people during the development of the ISP that they wanted?** | **Are all risks identified in Part II of the ISP addressed under an outcome in Part III?** |
| **All Service Type: Aggregate** | **96.62%** | **98.57%** | **97.37%** | **70.65%** |
| Agency Directed Respite | 92.31% | 100% | 100% | 69.23% |
| Case Management | - | - | - | - |
| Community Coaching | 95.08% | 98.41% | 96.83% | 77.78% |
| Community Engagement | 97.18% | 98.70% | 96.10% | 75.32% |
| Group Day | 96.10% | 98.73% | 98.73% | 67.09% |
| Group Home (Customized Rate) | 98.00% | 98.04% | 98.04% | 74.51% |
| Group Residential Support <= 4 Persons | 98.68% | 98.75% | 96.25% | 76.25% |
| Group Residential Support > 4 Persons | 100% | 98.67% | 96.00% | 65.33% |
| Independent Living Supports | 100% | 98.15% | 98.15% | 75.93% |
| In-Home Supports | 95.89% | 97.40% | 94.81% | 74.03% |
| Sponsored Residential | 92.00% | 98.73% | 100% | 65.82% |
| Supported Living | 100% | 98.25% | 98.25% | 80.70% |

*"-"Indicates question N/A to service type.*

# Appendix Z. Service Type: ISP Development & Implementation 3

Table 28 provides the provider service type-specific compliance results for four of the ISP development and implementation elements.

**Table 28—Service Type: ISP Development and Implementation Compliance Elements 3**

| ISP Development and Implementation Compliance Elements | | | | |
|---|---|---|---|---|
| **Provider Service Type** | **Outcomes are developed in the life area of Employment as appropriate.** | **Outcomes are developed in the life area of Integrated Community Involvement as appropriate.** | **Outcomes are developed in the life area of Community Living as appropriate.** | **Outcomes are developed in the life area of Safety & Security as appropriate.** |
| **All Service Type: Aggregate** | **75.41%** | **92.39%** | **97.44%** | **90.17%** |
| Agency Directed Respite | 80.00% | 100% | 100 % | 100% |
| Case Management | - | - | - | - |
| Community Coaching | 75.00% | 93.75% | 97.67% | 97.96% |
| Community Engagement | 83.33% | 96.15% | 98.39% | 93.75% |
| Group Day | 72.00% | 95.65% | 100% | 89.86% |
| Group Home (Customized Rate) | 84.21% | 96.67% | 95.12% | 85.37% |
| Group Residential Support <= 4 Persons | 73.91% | 85.42% | 100% | 93.65% |
| Group Residential Support > 4 Persons | 71.43% | 97.67% | 98.46% | 91.38% |
| Independent Living Supports | 86.11% | 94.29% | 90.24% | 83.72% |
| In-Home Supports | 79.31% | 90.57% | 92.06% | 83.33% |
| Sponsored Residential | 68.75% | 88.14% | 89.83% | 87.30% |
| Supported Living | 95.12% | 94.74% | 97.87% | 89.36% |

*"-"Indicates question N/A to service type.*

# Appendix AA. Service Type: ISP Development & Implementation 4

Table 29 provides the provider service type-specific compliance results for four of the ISP development and implementation elements.

**Table 29—Service Type: ISP Development and Implementation Compliance Elements 4**

| ISP Development and Implementation Compliance Elements | | | | |
|---|---|---|---|---|
| **Provider Service Type** | **Outcomes are developed in the life area of Healthy Living as appropriate.** | **Outcomes are developed in the life area of Social & Spirituality as appropriate.** | **Outcomes are developed in the life area of Citizenship & Advocacy as appropriate.** | **Are all needs in Part II assigned to Part III Outcome, including responsible provider?** |
| **All Service Type: Aggregate** | **95.20%** | **85.59%** | **92.65%** | **81.79%** |
| Agency Directed Respite | 100% | 100% | 100% | 69.23% |
| Case Management | - | - | - | - |
| Community Coaching | 95.16% | 87.10% | 100% | 90.48% |
| Community Engagement | 92.00% | 91.84% | 93.75% | 83.12% |
| Group Day | 96.00% | 89.58% | 88.41% | 75.95% |
| Group Home (Customized Rate) | 95.65% | 93.33% | 100% | 74.51% |
| Group Residential Support <= 4 Persons | 93.24% | 85.19% | 96.92% | 80.00% |
| Group Residential Support > 4 Persons | 95.77% | 83.33% | 95.16% | 86.67% |
| Independent Living Supports | 92.31% | 63.64% | 91.18% | 83.33% |
| In-Home Supports | 97.33% | 79.17% | 90.77% | 88.31% |
| Sponsored Residential | 97.37% | 77.78% | 95.00% | 87.34% |
| Supported Living | 92.98% | 80.49% | 98.08% | 84.21% |

*"-"Indicates question N/A to service type.*

# Appendix AB. Service Type: ISP Development & Implementation 5

Table 30 provides the provider service type-specific compliance results for four of the ISP development and implementation elements.

**Table 30—Service Type: ISP Development and Implementation Compliance Elements 5**

| ISP Development and Implementation Compliance Elements | | | | |
|---|---|---|---|---|
| **Provider Service Type** | **Are all outcomes identified in Part III linked to Part V PFS as appropriate?** | **Does the ISP include strategies for solving conflict or disagreement that occurs during the ISP meeting with ISP supports, outcomes, or individual decisions?** | **The ISP and/or other SC documentation confirmed review of the ISP was conducted with the individual quarterly or every 90 days.** | **The ISP and/or other SC documentation supports that the individual was given a choice regarding services and supports, including the individual's residential setting, and who provides them.** |
| **All Service Type: Aggregate** | **88.81%** | **88.05%** | **71.34%** | **87.64%** |
| Agency Directed Respite | 69.23% | - | 84.62% | 84.62% |
| Case Management | - | - | - | - |
| Community Coaching | 92.06% | 77.78% | 66.13% | 96.83% |
| Community Engagement | 88.31% | 84.21% | 76.62% | 90.91% |
| Group Day | 86.08% | 90.00% | 74.03% | 88.61% |
| Group Home (Customized Rate) | 82.35% | 100% | 72.92% | 86.27% |
| Group Residential Support <= 4 Persons | 93.75% | 88.24% | 67.95% | 81.25% |
| Group Residential Support > 4 Persons | 86.67% | 93.75% | 66.67% | 88.00% |
| Independent Living Supports | 90.74% | 50.00% | 92.16% | 94.44% |
| In-Home Supports | 90.91% | 75.00% | 70.67% | 89.61% |
| Sponsored Residential | 88.61% | 94.44% | 67.09% | 88.61% |
| Supported Living | 92.98% | 100% | 74.55% | 75.44% |

*"-"Indicates question N/A to service type.*

# Appendix AC. Service Type: ISP Development & Implementation 6

Table 31 provides the provider service type-specific compliance results for three of the ISP development and implementation elements.

**Table 31—Service Type: ISP Development and Implementation Compliance Elements 6**

| ISP Development and Implementation Compliance Elements | | | |
|---|---|---|---|
| **Provider Service Type** | **The ISP includes signatures of the individual (or representative) and all providers responsible for its implementation.** | **The ISP and/or the individual's file included documentation the support coordinator identified and resolved any unidentified or inadequately addressed risk, injury, need, or change in status, a deficiency in the individual's support plan or its implementation, or a discrepancy between the implementation of supports and services and the individual's strengths and preferences.** | **The ISP was developed according to the processes required.** |
| **All Service Type: Aggregate** | **92.73%** | **19.58%** | **31.78%** |
| Agency Directed Respite | 100% | 0.00% | 0.00% |
| Case Management | - | - | - |
| Community Coaching | 95.24% | 13.04% | 30.16% |
| Community Engagement | 84.42% | 22.73% | 35.06% |
| Group Day | 96.20% | 18.97% | 32.91% |
| Group Home (Customized Rate) | 94.12% | 19.51% | 25.49% |
| Group Residential Support <= 4 Persons | 93.75% | 14.29% | 32.50% |
| Group Residential Support > 4 Persons | 89.33% | 17.78% | 26.67% |
| Independent Living Supports | 92.59% | 26.67% | 29.63% |
| In-Home Supports | 92.21% | 22.22% | 36.36% |
| Sponsored Residential | 93.67% | 25.00% | 25.32% |
| Supported Living | 96.49% | 25.93% | 35.09% |

*"-"Indicates question N/A to service type.*

# Appendix AD. Service Type: Risk/Harm

Table 32 provides the provider service type-specific compliance results for the risk/harm elements.

**Table 32—Service Type: Risk/Harm Compliance Elements**

| Risk/Harm Compliance Elements | | | |
|---|---|---|---|
| **Provider Service Type** | **Is there evidence of completion of an annual physical exam?** | **Is there evidence of completion of an annual dental exam?** | **Is there an approved modification in place for health and safety risks OR is the individual in the process of requesting such approval?** |
| **All Service Type: Aggregate** | **75.80%** | **58.67%** | **56.40%** |
| Agency Directed Respite | 100% | 33.33% | - |
| Case Management | - | - | - |
| Community Coaching | 85.71% | 60.00% | 28.57% |
| Community Engagement | 81.67% | 55.00% | 50.00% |
| Group Day | 68.18% | 48.48% | 50.00% |
| Group Home (Customized Rate) | 80.00% | 53.33% | 69.23% |
| Group Residential Support <= 4 Persons | 81.43% | 62.86% | 57.14% |
| Group Residential Support > 4 Persons | 78.46% | 64.62% | 53.85% |
| Independent Living Supports | 66.67% | 64.29% | 0.00% |
| In-Home Supports | 67.27% | 60.00% | 50.00% |
| Sponsored Residential | 83.78% | 72.97% | 87.50% |
| Supported Living | 67.27% | 65.45% | 42.86% |

*"-"Indicates question N/A to service type.*

# Appendix AE. Service Type: Provider Capacity and Competency 1

Table 33 provides the service type-specific compliance results for four of the provider capacity and competency elements.

**Table 33—Service Type: Provider Capacity and Competency 1**

| Provider Capacity and Competency | | | |
|---|---|---|---|
| **Provider Service Type** | **Is there a record of the individual receiving and signing their HCBS rights disclosure on an annual basis?** | **Is the individual's/ provider's environment neat and clean?** | **Was the person's/ provider's environment accessible?** |
| **All Service Type: Aggregate** | **79.33%** | **97.68%** | **98.87%** |
| Agency Directed Respite | 100% | 100% | 100% |
| Case Management | - | - | - |
| Community Coaching | 80.00% | 100% | 100% |
| Community Engagement | 89.58% | 100% | 100% |
| Group Day | 76.36% | 98.39% | 100% |
| Group Home (Customized Rate) | 74.42% | 86.67% | 100% |
| Group Residential Support <= 4 Persons | 73.13% | 98.53% | 97.06% |
| Group Residential Support > 4 Persons | 80.33% | 98.46% | 98.46% |
| Independent Living Supports | 75.00% | 96.55% | 100% |
| In-Home Supports | 78.57% | 86.49% | 94.59% |
| Sponsored Residential | 85.71% | 98.63% | 100% |
| Supported Living | 80.49% | 94.34% | 100% |

*"-"Indicates question N/A to service type.*

# Appendix AF. Service Type: Provider Capacity and Competency 2

Table 34 provides the service type-specific compliance results for four of the provider capacity and competency elements.

**Table 34—Service Type: Provider Capacity and Competency 2**

| Provider Capacity and Competency | | | | |
|---|---|---|---|---|
| **Provider Service Type** | **Were staff engaging with the individual based on the person's preference and interests?** | **Was the person being offered choices throughout the visit?** | **Were staff implementing the Part V as written?** | **For individuals with behavioral support plans were staff addressing behaviors per the written plan?** |
| **All Service Type: Aggregate** | **98.72%** | **97.76%** | **97.14%** | **100%** |
| Agency Directed Respite | - | - | - | - |
| Case Management | - | - | - | - |
| Community Coaching | 100% | 100% | 100% | 100% |
| Community Engagement | 100% | 100% | 97.87% | 100% |
| Group Day | 100% | 98.11% | 95.92% | 100% |
| Group Home (Customized Rate) | 97.37% | 100% | 100% | 100% |
| Group Residential Support <= 4 Persons | 96.72% | 96.61% | 96.36% | 100% |
| Group Residential Support > 4 Persons | 96.77% | 94.83% | 98.21% | 100% |
| Independent Living Supports | 96.67% | 100% | 100% | 100% |
| In-Home Supports | 97.22% | 97.14% | 96.97% | 100% |
| Sponsored Residential | 100% | 98.57% | 98.48% | 100% |
| Supported Living | 95.74% | 100% | 100% | 100% |

*"-"Indicates question N/A to service type.*

# Appendix AG. Service Type: Provider Capacity and Competency 3

Table 35 provides the service type-specific compliance results for three of the provider capacity and competency elements.

**Table 35—Service Type: Provider Capacity and Competency 3**

| Provider Capacity and Competency | | | |
|---|---|---|---|
| **Provider Service Type** | **Were staff adhering to medical and behavioral protocols as outlined in the plan?** | **Were staff able to describe what community inclusion looks like for the individual?** | **Did the staff demonstrate competency in supporting the individual?** |
| **All Service Type: Aggregate** | **99.44%** | **96.21%** | **99.78%** |
| Agency Directed Respite | - | 100% | 100% |
| Case Management | - | - | - |
| Community Coaching | 96.15% | 100% | 100% |
| Community Engagement | 100% | 100% | 98.21% |
| Group Day | 100% | 93.94% | 100% |
| Group Home (Customized Rate) | 100% | 97.78% | 100% |
| Group Residential Support <= 4 Persons | 97.73% | 100% | 100% |
| Group Residential Support > 4 Persons | 100% | 92.31% | 100% |
| Independent Living Supports | 94.74% | 87.80% | 100% |
| In-Home Supports | 100% | 94.55% | 100% |
| Sponsored Residential | 100% | 97.30% | 100% |
| Supported Living | 100% | 90.91% | 100% |

*"-"Indicates question N/A to service type.*

# Appendix AH. Service Type: Provider Capacity and Competency 4

Table 36 provides the service type-specific compliance results for four of the provider capacity and competency elements.

**Table 36—Service Type: Provider Capacity and Competency 4**

| Provider Capacity and Competency | | | | |
|---|---|---|---|---|
| **Provider Service Type** | **Are staff familiar with adaptive equipment needs?** | **Were staff utilizing adaptive equipment the individual had as part of their plan?** | **Are staff able to describe things important to and important for the individual?** | **Was staff able to describe the outcomes being worked on in this environment?** |
| **All Service Type: Aggregate** | **96.65%** | **92.82%** | **99.10%** | **96.46%** |
| Agency Directed Respite | 66.67% | 100% | 100% | 100% |
| Case Management | - | - | - | - |
| Community Coaching | 100% | 93.75% | 100% | 100% |
| Community Engagement | 100% | 94.44% | 98.33% | 100% |
| Group Day | 93.33% | 85.71% | 100% | 95.45% |
| Group Home (Customized Rate) | 100% | 81.82% | 100% | 93.33% |
| Group Residential Support <= 4 Persons | 100% | 100% | 98.57% | 95.71% |
| Group Residential Support > 4 Persons | 92.11% | 94.29% | 98.46% | 95.38% |
| Independent Living Supports | 100% | 100% | 95.24% | 97.62% |
| In-Home Supports | 95.45% | 94.12% | 98.18% | 94.55% |
| Sponsored Residential | 100% | 92.11% | 100% | 98.65% |
| Supported Living | 100% | 100% | 94.55% | 94.55% |

*"-"Indicates question N/A to service type.*

# Appendix AI. Service Type: Provider Capacity and Competency 5

Table 37 provides the service type-specific compliance results for four of the provider capacity and competency elements.

**Table 37—Service Type: Provider Capacity and Competency 5**

| Provider Capacity and Competency | | | | |
|---|---|---|---|---|
| **Provider Service Type** | **Could the staff describe the medical support needs of the individuals?** | **Were staff familiar with the medical protocols to support the person?** | **Could the staff describe behavioral support needs?** | **Were staff familiar with behavioral support plans or protocols developed to support the person?** |
| **All Service Type: Aggregate** | **95.41%** | **95.18%** | **95.95%** | **93.01%** |
| Agency Directed Respite | 100% | 100% | 100% | 100% |
| Case Management | - | - | - | - |
| Community Coaching | 96.88% | 93.75% | 97.06% | 96.30% |
| Community Engagement | 96.30% | 97.87% | 97.50% | 93.55% |
| Group Day | 94.92% | 94.00% | 89.47% | 83.87% |
| Group Home (Customized Rate) | 88.10% | 90.00% | 97.73% | 95.45% |
| Group Residential Support <= 4 Persons | 95.16% | 93.10% | 100% | 97.56% |
| Group Residential Support > 4 Persons | 91.80% | 94.00% | 95.65% | 100% |
| Independent Living Supports | 93.94% | 100% | 100% | 100% |
| In-Home Supports | 93.88% | 97.67% | 97.37% | 93.33% |
| Sponsored Residential | 100% | 98.36% | 100% | 97.50% |
| Supported Living | 96.15% | 86.36% | 96.88% | 100% |

*"-"Indicates question N/A to service type.*

# Appendix AJ. Service Type: Provider Capacity and Competency 6

Table 38 provides the service type-specific compliance results for three of the provider capacity and competency elements.

**Table 38—Service Type: Provider Capacity and Competency 6**

| Provider Capacity and Competency | | | |
|---|---|---|---|
| **Provider Service Type** | **Does the staff know what medications the person is taking or where to locate this information?** | **Can the staff list the most common side effects of the medications the person is on or where to locate that information?** | **Can you tell me what person-centered care means?** |
| **All Service Type: Aggregate** | **98.02%** | **93.66%** | **94.51%** |
| Agency Directed Respite | 100% | 100% | 100% |
| Case Management | - | - | - |
| Community Coaching | 90.32% | 90.32% | 94.29% |
| Community Engagement | 96.23% | 94.44% | 98.33% |
| Group Day | 98.33% | 91.80% | 95.45% |
| Group Home (Customized Rate) | 100% | 95.56% | 95.56% |
| Group Residential Support <= 4 Persons | 100% | 95.59% | 92.86% |
| Group Residential Support > 4 Persons | 100% | 96.88% | 92.31% |
| Independent Living Supports | 94.74% | 89.47% | 97.62% |
| In-Home Supports | 90.57% | 81.13% | 85.45% |
| Sponsored Residential | 100% | 100% | 98.65% |
| Supported Living | 98.11% | 98.11% | 92.73% |

*"-"Indicates question N/A to service type.*

Table 39 provides the service type-specific compliance results for two of the provider capacity and competency elements.

**Table 39—Service Type: Provider Capacity and Competency 6**

| Provider Capacity and Competency | | | | |
|---|---|---|---|---|
| **Service Type** | **When were you last trained on Medication Administration?** | | **When were you last trained on Crisis Intervention?** | |
| | **>12 months** | **Never** | **>12 months** | **Never** |
| **All Service Type: Aggregate** | **9.88%** | **5.55%** | **6.41%** | **1.39%** |

| Provider Capacity and Competency | | | | |
|---|---|---|---|---|
| **Service Type** | **When were you last trained on Medication Administration?** | | **When were you last trained on Crisis Intervention?** | |
| | **>12 months** | **Never** | **>12 months** | **Never** |
| Agency Directed Respite | 0.00% | 0.00% | 0.00% | 0.00% |
| Case Management | 14.29% | 28.57% | 28.57% | 0.00% |
| Community Coaching | 8.57% | 11.43% | 0.00% | 0.00% |
| Community Engagement | 10.00% | 3.33% | 1.67% | 1.67% |
| Group Day | 12.12% | 9.09% | 4.55% | 1.52% |
| Group Home (Customized Rate) | 4.44% | 0.00% | 6.67% | 0.00% |
| Group Residential Support <= 4 Persons | 2.86% | 0.00% | 4.29% | 2.86% |
| Group Residential Support > 4 Persons | 6.15% | 0.00% | 3.08% | 0.00% |
| Independent Living Supports | 21.43% | 23.81% | 28.57% | 2.38% |
| In-Home Supports | 14.55% | 12.73% | 9.09% | 3.64% |
| Sponsored Residential | 5.41% | 0.00% | 4.05% | 0.00% |
| Supported Living | 18.18% | 1.82% | 5.45% | 1.82% |

*Statewide, regional, and service type breakdown for compliance elements specific to training on medication administration and crisis intervention are offered for information only. DBHDS has not established a compliance threshold for these elements.*

# Appendix AK. Region: Individual Interview Responses

Table 40 provides the region-specific individual interview responses.

**Table 40—Region: Individual Interview Responses**

| Individual Interview Responses<br>Percent Positive<br>(Yes/Yes+No) | | | | | |
|---|---|---|---|---|---|
| **Individual Interview Questions** | **Region 1** | **Region 2** | **Region 3** | **Region 4** | **Region 5** |
| Do you like living here? | 93% | 95% | 97% | 92% | 97% |
| Would you like to live somewhere else?[1] | 37% | 31% | 33% | 42% | 26% |
| Did you choose the people you live with? | 84% | 74% | 89% | 57% | 85% |
| Do you have a key to your home? | 81% | 76% | 82% | 76% | 81% |
| Do you have a key to your bedroom? | 74% | 56% | 70% | 35% | 74% |
| Do you open your mail or help with opening your mail? | 98% | 94% | 94% | 89% | 89% |
| Do you have visitors at your home? | 95% | 93% | 88% | 93% | 97% |
| Do you like attending this program? | 95% | 91% | 100% | 93% | 97% |
| Did you get to choose the people you participate in the group with? | 88% | 100% | 94% | 100% | 94% |
| Would you like to do something else during the day?[1] | 18% | 38% | 40% | 47% | 41% |
| Do you like your staff? | 97% | 98% | 98% | 97% | 99% |
| If you want to go somewhere, does your provider take you? | 98% | 100% | 98% | 95% | 99% |
| Can you get where you want to go without problems? | 92% | 98% | 92% | 88% | 96% |
| Do you get to do those things as much as you would like? | 81% | 79% | 84% | 78% | 94% |
| Do you want to attend a church/synagogue/mosque or other religious activity of your choice? | 61% | 63% | 70% | 67% | 70% |
| Do you attend religious services? | 54% | 57% | 67% | 49% | 62% |

| Individual Interview Responses<br>Percent Positive<br>(Yes/Yes+No) | | | | | |
|---|---|---|---|---|---|
| **Individual Interview Questions** | **Region 1** | **Region 2** | **Region 3** | **Region 4** | **Region 5** |
| Are you registered to vote? | 55% | 55% | 60% | 66% | 52% |
| Did you vote in the last election? | 40% | 36% | 50% | 51% | 39% |
| Do you participate in your banking? | 55% | 83% | 83% | 54% | 69% |
| Do you have a job? | 15% | 46% | 28% | 28% | 31% |
| Is your support coordinator currently addressing your employment goals? | 86% | 86% | 92% | 77% | 88% |
| Do you feel safe here? | 97% | 94% | 100% | 91% | 98% |

[1]*These compliance elements were measured using scoring criteria that are inverse, meaning a lower percentage indicates better compliance. Compliance cut-off standards remained the same, hence compliance percentages greater than 10% indicate areas with opportunities for improvement.*

# Appendix AL. Service Type: Individual Interview Responses

Table 41 provides the provider service type-specific individual interview responses.

**Table 41—Service Type: Individual Interview Responses**

| Individual Interview Responses<br>Percent Positive<br>(Yes/Yes+No) | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Individual Interview Questions** | **ADR** | **CMA** | **CCO** | **CEN** | **GDY** | **GHC** | **GRS** | **GRL** | **ILS** | **IHS** | **SPR** | **SUL** |
| Do you like living here? | - | - | - | - | - | 96.43% | 95.74% | 91.11% | 93.55% | 94.29% | 98.33% | 91.84% |
| Would you like to live somewhere else?[1] | - | - | - | - | - | 30.77% | 26.19% | 51.28% | 33.33% | 48.39% | 19.61% | 34.78% |
| Did you choose the people you live with? | - | - | - | - | - | 60.87% | 64.29% | 70.59% | 80.00% | 100% | 87.80% | 91.67% |
| Do you have a key to your home? | - | - | - | - | - | 57.14% | 65.91% | 72.09% | 100% | 75.76% | 80.77% | 97.96% |
| Do you have a key to your bedroom? | - | - | - | - | - | 62.07% | 68.18% | 71.43% | 50.00% | 45.16% | 77.36% | 44.44% |
| Do you open your mail or help with opening your mail? | - | - | - | - | - | 92.59% | 85.37% | 88.37% | 100% | 93.75% | 93.75% | 95.74% |
| Do you have visitors at your home? | - | - | - | 97.37% | - | 100% | 88.89% | 86.05% | 96.77% | 96.97% | 96.49% | 93.62% |
| Do you like attending this program? | - | - | 96.55% | 95.74% | 95.35% | - | - | - | - | - | - | - |
| Did you get to choose the people you participate in the group with? | - | - | 92.31% | 95.12% | 92.50% | - | - | - | - | - | - | - |
| Would you like to do something else during the day?[1] | - | - | 21.74% | 41.03% | 27.78% | 34.78% | 38.10% | 55.56% | 40.74% | 33.33% | 36.36% | 33.33% |
| Do you like your staff? | - | - | 100% | 100% | 95.56% | 96.43% | 95.83% | 95.92% | 100% | 100% | 100% | 95.83% |
| If you want to go somewhere, does your provider take you? | - | - | 100% | 97.73% | 100% | 100% | 95.65% | 92.86% | 96.77% | 100% | 100% | 97.87% |
| Can you get where you want to go without problems? | - | - | 92.00% | 97.56% | 94.29% | 96.00% | 86.36% | 86.84% | 100% | 96.88% | 95.65% | 89.13% |

| Individual Interview Responses<br>Percent Positive<br>(Yes/Yes+No) | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Individual Interview Questions** | **ADR** | **CMA** | **CCO** | **CEN** | **GDY** | **GHC** | **GRS** | **GRL** | **ILS** | **IHS** | **SPR** | **SUL** |
| Do you get to do those things as much as you would like? | - | - | 80.00% | 92.11% | 85.29% | 87.50% | 76.74% | 80.00% | 86.67% | 84.38% | 95.65% | 78.05% |
| Do you want to attend a church/synagogue/mosque or other religious activity of your choice? | - | - | 54.17% | 72.73% | 66.67% | 64.29% | 62.79% | 70.00% | 63.33% | 78.79% | 63.27% | 64.58% |
| Do you attend religious services? | - | - | 46.15% | 73.81% | 55.26% | 46.43% | 56.52% | 57.50% | 56.67% | 69.70% | 60.78% | 52.08% |
| Are you registered to vote? | - | - | 20.00% | 67.86% | 60.71% | 35.00% | 48.57% | 64.29% | 78.57% | 66.67% | 39.53% | 68.75% |
| Did you vote in the last election? | - | - | 15.38% | 35.71% | 52.17% | 22.22% | 27.59% | 39.13% | 67.86% | 63.33% | 31.71% | 51.16% |
| Do you participate in your banking? | - | - | 70.37% | 73.68% | 60.00% | 51.85% | 59.09% | 63.16% | 90.00% | 69.70% | 68.63% | 63.64% |
| Do you have a job? | - | - | 14.81% | 30.30% | 14.29% | 8.33% | 18.42% | 20.59% | 73.91% | 37.93% | 15.22% | 55.81% |
| Is your support coordinator currently addressing your employment goals? | - | - | 87.50% | 77.78% | 91.30% | 94.44% | 75.00% | 78.95% | 100% | 87.50% | 87.88% | 88.24% |
| Do you feel safe here? | - | - | 100% | 97.83% | 97.62% | 92.59% | 95.74% | 93.02% | 90.32% | 100% | 98.15% | 91.67% |

[1]*These compliance elements were measured using scoring criteria that are inverse, meaning a lower percentage indicates better compliance. Compliance cut-off standards remained the same, hence compliance percentages greater than 10% indicate areas with opportunities for improvement.*
*"-"Indicates question N/A to service type.*

***Provider Service Type:***
*ADR: Agency Directed Respite Care*
*CMA: Case Management*
*CCO: Community Coaching*
*CEN: Community Engagement*
*GHC: Group Home Customized Rate*
*GRS: Group Residential Support <=4 Persons*
*GRL: Group Residential Support >4 Persons*
*ILS: Independent Living Supports*
*IHS: In-Home Supports*
*SPR: Sponsored Residential*
*SUL: Supported Living*

# Appendix AM. Region: Substitute Decision Maker/Family Interview Responses

Table 42 provides the region-specific Substitute Decision Maker (SDM)/Family Member interview responses.

**Table 42—Region: SDM/Family Member Interview Responses**

| SDM/Family Member Interview Responses<br>Percent Positive<br>(Yes/Yes+No) | | | | | |
|---|---|---|---|---|---|
| **SDM/Family Member Interview Questions** | **Region 1** | **Region 2** | **Region 3** | **Region 4** | **Region 5** |
| Did the SC provide the individual with a choice in service providers, including a choice in SC? | 91% | 100% | 93% | 89% | 96% |
| Did the SC discuss employment goals and options with the individual? | 93% | 95% | 93% | 86% | 93% |
| Did the SC discuss community involvement opportunities with the individual? | 95% | 95% | 97% | 95% | 96% |
| Are all of the individual's needs and supports currently being met? | 85% | 81% | 93% | 83% | 91% |
| Did you have an opportunity to participate in the ISP development? | 96% | 100% | 97% | 96% | 96% |
| Do you feel the ISP is representative of the person's needs? | 100% | 100% | 93% | 100% | 96% |
| Does the SDM/Family confirm there are no concerns regarding the current service providers? | 83% | 91% | 83% | 90% | 86% |

# Appendix AN. Service Type: Substitute Decision Maker/Family Interview Responses

Table 43 provides the provider service type-specific SDM/Family Member interview responses.

**Table 43—Service Type: SDM/Family Member Interview Responses**

| SDM/Family Member Interview Responses<br>Percent Positive<br>(Yes/Yes+No) | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **SDM/Family Member Interview Questions** | **ADR** | **CMA** | **CCO** | **CEN** | **GDY** | **GHC** | **GRS** | **GRL** | **ILS** | **IHS** | **SPR** | **SUL** |
| Did the SC provide the individual with a choice in service providers, including a choice in SC? | 100% | - | 100% | 100% | 100% | 95.00% | 84.38% | 85.00% | 100% | 100% | 94.34% | 90.91% |
| Did the SC discuss employment goals and options with the individual? | 100% | - | 87.50% | 100% | 81.82% | 100% | 93.55% | 89.47% | 100% | 89.66% | 92.31% | 86.36% |
| Did the SC discuss community involvement opportunities with the individual? | 100% | - | 100% | 100% | 95.45% | 95.24% | 96.88% | 90.00% | 100% | 90.00% | 96.08% | 95.00% |
| Are all of the individual's needs and supports currently being met? | 100% | - | 94.12% | 79.31% | 100% | 80.95% | 96.88% | 86.36% | 76.92% | 90.00% | 88.68% | 73.91% |
| Did you have an opportunity to participate in the ISP development? | 100% | - | 100% | 93.10% | 100% | 95.00% | 88.24% | 90.48% | 100% | 100% | 100% | 100% |
| Do you feel the ISP is representative of the person's needs? | 100% | - | 94.44% | 96.55% | 100% | 90.48% | 93.75% | 100% | 100% | 100% | 100% | 100% |
| Does the SDM/Family confirm there are no concerns regarding the current service providers? | 100% | - | 94.44% | 79.31% | 100% | 71.43% | 85.29% | 78.26% | 78.57% | 93.33% | 92.45% | 82.61% |

*"-"Indicates question N/A to service type.*